

**CITY OF NEWTON  
PURCHASING DEPARTMENT**

***CONTRACT FOR HUMAN RESOURCES***

**PROJECT MANUAL:  
REQUEST FOR PROPOSAL  
STOP LOSS REINSURANCE  
*RFP #14-139***

**RFP:Opening June 26, 2014 at 10:00 am**

**JUNE 2014**

**Setti Warren, Mayor**

**GROUP MEDICAL REINSURANCE (STOP LOSS)**

**REQUEST FOR PROPOSAL #14-139**

**FOR COVERAGE PERIOD JULY 1, 2014 THRU JUNE 30, 2015**

**PROPOSAL Submission Instructions**

The City of Newton is not required by law to seek competitive quotes for Insurance Coverage. M.G.L. c. 30B, §1(b)(12). Accordingly, while it is the City's preference to use a competitive process, it is not required to follow any specified procedure or laws. Moreover, the terms and conditions of this procurement are exclusively those contained in this Request For Proposal (RFP).

The City of Newton will be the sole judge of whether or not a proposal meets the criteria of the RFP, and its decision shall be final.

The City of Newton will be the sole judge of whether or not a particular proposal is most advantageous to the City of Newton compared based on the selection criteria, and its decision shall be final.

**RFP DATES:**

Release Date: June 12, 2014 at 10:00 a.m.

Questions (no later than): June 20, 2014 at 12:00 noon

Proposal Due Date: June 26, 2014 at 10:00 a.m.

Award shall be made by: within 60 days of opening

Contract Term: July 1, 2014 – June 30, 2015 with two one year extensions

# STOP LOSS REINSURANCE BID SPECIFICATIONS

## Services to Be Provided:

The successful proposer will provide, for the service period bided, stop-loss coverage for the City of Newton's self-insured health plans. The selected vendor will be responsible for exchanging and verifying information with the Tufts Total Health Plan and Harvard Pilgrim Health Care concerning claims near or exceeding the selected attachment point. It will be the sole responsibility of the vendor to develop a working relationship with Tufts and Harvard Pilgrim that produce accurate and timely information and allows the City to be reimbursed promptly.

## Proposal Submission Instructions

All applicable experience data that is available is included in this RFP. Should any additional data become available during the proposal process, we will immediately forward the information to all proposers.

RFP Documents will be available on line at [www.newtonma.gov/bids](http://www.newtonma.gov/bids) , under the Invitation for Bid link or pickup at the Purchasing Department **after 10:00 a.m., June 12, 2014**. There will be no charge for contract documents.

Completed Proposals shall be submitted no later than **10:00 a.m. on June 26, 2014**.

Proposals shall consist of two parts: (i) a Technical Proposal, which shall consist of all information responsive to this RFP except the City will pay for the services hereunder and (ii) a Price Proposal, which shall consist solely of the fee proposal. Each proposer shall submit a **Technical Proposal** (2) and a **Price Proposal** (1) Please ensure that "Technical" & "Price" Proposals are submitted in **separate sealed envelopes**. A Technical Proposal which includes Price Proposal information may be rejected as non-responsive.

Proposals shall be delivered to: *Chief Procurement Officer*, Room 204, City of Newton, 1000 Commonwealth Avenue, Newton, MA 02459. The Technical Proposal shall be in a sealed envelope clearly marked "**RFP #14-139 Technical Proposal for Reinsurance Coverage**"; the Price Proposal shall be in a sealed envelope clearly marked "**RFP #14-139 Price Proposal for Reinsurance Coverage**".

Questions involving procedural or technical matters related to this RFP shall be answered if received in writing no later than **12:00 p.m., June 20, 2014, addressed to:**

City of Newton - Purchasing Dept.  
*Chief Procurement Officer*  
1000 Commonwealth Avenue  
Newton, MA 02459

FAX (617) 796-1227 or  
**E-mail: [purchasing@newtonma.gov](mailto:purchasing@newtonma.gov)**

It is the responsibility of each proposer to ensure that it has received and acknowledged any/all addenda to this RFP. Anyone on record as having received this RFP will be faxed the addendum automatically. If you have downloaded this RFP from the City's website, you must email: [purchasing@newtonma.gov](mailto:purchasing@newtonma.gov) or fax us your company's name, address, phone, and fax as well as the BID/RFP number and project title in order to be added to the addendum distribution list..

**Please ensure you've acknowledged any/all addenda that have been issued for this RFP in both Technical and Price Proposals.**

The "**Price Proposal**" shall be submitted on the forms included herein as **Attachment F**. No reference to cost may be made in any other section of your proposal. Proposers shall submit the following:

- **Two proposals for the "Technical" portion of the RFP**
- **One proposal for the "Price" portion of the RFP**

Proposers are encouraged to quote on each of the attachment point options specified on the price pages.

The City shall award a contract based on the most advantageous proposal, based on an evaluation of the Technical and Price Proposals based on the Selection Criteria set forth at p. 9 below. The City shall select the attachment point and run-out option at its discretion and as may be in the public interest.

### **Current Reinsurance Coverage and Plan Design:**

Reinsurance is currently provided by Westport Insurance Corporation and covers the City's medical benefits administered by both Tufts Health Plan and Harvard Pilgrim. It includes the prescription drug benefits administered by both plans. The attachment point is \$250,000 specific.

The current plans administered by Tufts are an EPO Plan which only allows utilization of in-network providers, a PPO Plan in which utilization of in-network providers has been at 85% with the exception of the Out-of-Network subset (see #1 below), and a POS plan with only retirees enrolled who retired before April 1, 2012 and who have not become Medicare eligible yet.

The Tufts POS/PPO Plan includes the following feature:

Out of Area Group - The Out-of-Area Group is a subset of the Point of Service Plan. Members in this group have all of their claims processed as though all the providers are in the network. (All claims are paid at 100% of the Usual and Customary amount.) Members are responsible for any balanced billing. Less than 1% of claims submitted by this group are with network providers. There are 46 Individual and 17 Family contracts in the Out of Area Group.

Other current reinsurance program features are the following:

- 1) All Harvard Pilgrim Claims are in network.
- 2) There are no lifetime maximums with any of the plans.
- 3) The plan design for the plan year starting July 1, 2014 will remain unchanged from the current plan year.
- 4) Prescription coverage includes mandatory Mail Order coverage along with pharmacy coverage.
- 5) The City also now utilizes the purchase of Canadian drugs for its members. This program is not to be included in this bid.
- 6) The City is not able to provide a census that includes zip codes.
- 7) The attachments listed below are included in the bid package.

Attachment A - Current Reinsurance Rates and policy limits

Attachment B - Subscriber/member demographic profile for Tufts and HP

(All Ages listed are as of May 1, 2014)

Attachment C - Enrollment/Claims monthly history since FY 11 for Tufts and  
Since FY 11 for Harvard

Attachment D - Large Claims of prior years and current year (over \$100,000)

Attachment E - Plan Benefit Summaries

Attachment F - Price Proposal Submission Form (**To be submitted separately**)

Attachment G – Statement of Compliance – To be included in bid.

Attachment H - Rate History and Miscellaneous Information

### **Award Decision Criteria:**

In order for a proposer to be considered for a Group Reinsurance and Reporting contract award, it must be deemed responsible and be responsive to all submission requirements met and with responses submitted on forms provided, and must meet the Contractual Requirements as set forth in this RFP. From among those complete and correctly submitted proposals meeting the requirements and specifications, the Contract will be awarded based on the selection criteria in this RFP.

## Purchaser's Rights:

The City reserves the right to accept or reject any and all proposals.

The City reserves the right to reject any proposal which does not comply with any and all applicable state and federal statutes.

The City reserves the right to reject any proposal, which does not meet the requirements. The City will be the sole judge of whether or not a proposal meets these Requirements, and the City's decision will be final.

The City reserves the right to reject any proposal that is not submitted according to the prescribed format, not properly signed, or otherwise contrary to instructions.

The City reserves the right to reject any and all proposals if there is reason to believe that collusion exists among the brokers/carriers.

The City reserves the right to independently verify the accuracy of information supplied in the proposals.

The City reserves the right to reject any proposal which is subject to final underwriting approval and/or which does not ultimately meet contractual requirements as stated in the general requirements.

The City reserves the right to select the final attachment point from among the submitted attachment points.

Information prepared and submitted by Proposers in response to this Request for Proposals shall be the property of the City of Newton.

## General Requirements:

A responsive proposal must include the following:

1. Letter of transmittal signed by the individual authorized to negotiate for and contractually bind the carrier, stating that the offer is effective for at least sixty (60) days from the deadline for the submission of the proposals (effective date of policy is July 1, 2014). The letter should also state the proposer understands the coverage to be provided; and make a positive commitment to provide the coverage under the contractual requirements specified in this RFP within the required policy period.
2. Signed Attestation (Form enclosed).
3. A list with names, addresses, and phone numbers of contact persons of Massachusetts municipalities for which the Broker and Carrier are currently contracted to provide similar services. Please provide accounts with 500 or more covered subscribers.
4. All price proposals shall be submitted on **Attachment F** of this proposal and be submitted in a separate sealed envelope. They shall be on the incurred/paid basis specified on **Attachment F**.
5. The broker/stop loss administrator selected through this process will be required to conform to the reporting and other service requirements specified in this Request for proposals unless the City of Newton exercises its right to engage an independent stop loss tracking, filing and reporting firm.
6. All proposals must provide reinsurance coverage for Tufts POS, Tufts PPO, Tufts EPO and Harvard Pilgrim HMO.
7. All proposals must provide reinsurance for all members of the plans named in item #6 above, i.e. employees, retirees, and dependents.
8. Reimbursement\_factor: All proposals must provide a reimbursement factor of 100% of covered medical expenses and prescription drug coverage subject to applicable plan maximums.
9. Lifetime\_Maximum: All policies proposed must provide a minimum of a lifetime Maximum benefit payable of \$2 million per claimant.
10. Proposals must describe stop loss Claims Tracking, Filing, and Reporting services. Proposals must include a detailed description of the process by which claims will be monitored and tracked including the names of the company (ies) that will

track and file the claims with the carrier. (The City of Newton reserves the right to engage an independent claims tracking, filing and reporting company.)

11. Proposals must describe how information on status of claims with potential to reach the stop loss deductible and information on status of claims exceeding the deductible will be reported to the City of Newton.

Proposals must include provisions for monthly reporting of the following data:

For the monthly report of claims at or above 50% of the deductible:

Claimant name, coverage ID number, dollar amount of claims incurred during the policy period, dollar amount under the deductible, month and year of most recent paid claims data reviewed for this report.

For the monthly report of claims at or above the stop loss deductible:

Claimant name, coverage ID number, dollar amount of claims incurred to date during the policy period, dollar amount exceeding the deductible, dollar amount of claims detail submitted to reinsurance carrier, outstanding detail to be submitted, dollar amount of reimbursement to date, dollar amount of outstanding reimbursements, month and year of most recent paid claims data reviewed for this report.

Proposals must include sample reports and confirm in the proposal that reports will be sent to the City of Newton or its designees each month beginning in September 2014 and throughout the run-out period(s) of the policy(ies). If there is no activity for a particular month, the stop loss tracker and filer is required to supply a "Report of No Activity" stating the most recent paid claims data reviewed.

12. Proposals must comply with all applicable federal and state statutes.

*Note: A proposal from a non-admitted carrier will not be considered and will not be accepted unless there is no proposal submitted from an admitted carrier.*

13. Proposers are requested to provide a retrospective rebate proposal (or comparable proposal such as up-front discounted premium arrangement) that would apply if claims paid by the reinsurance carrier are 50% or less of premium.
14. A completed and signed Statement of Compliance With Contractual Requirements (**Attachment G**)
15. A completed and signed Proposer's Questionnaire (pp. 10-12) and Vendor Minimum Requirements for m (p. 8)

### **Who Can Bid and Policy Regarding Brokers:**

Both insurance companies and brokers can bid directly.

The City's policy regarding brokers is as follows:

The City of Newton has a policy of not having a Broker of Record for the City. For all bids, it is neither in favor of nor opposed to having brokers participate in the bidding process. It will accept all bids, directly from insurance companies and from brokers and evaluate them based upon their merit and their cost. It will not provide letters of authorization to any brokers. In the case of the same winning bid being provided by an insurance company and/or one or more brokers, the Director of Human Resources, in consultation with the Director of Purchasing and the Law Department, will make the decision as to which bid is the most advantageous for The City of Newton, and which one will be awarded.

**The City assumes no responsibility for broker fees, which shall be the responsibility of the entity providing the stop loss reinsurance services.**

### **Bid Requirements:**

The Technical Proposal shall state that the proposer acknowledges and incorporates as required each of the items listed below.

1. The effective date will be July 1, 2014.
2. The current contract reflects an incurred in 12 months, paid in 18 months basis. Quotes are being sought on an incurred in

12 months and paid in 18 month basis for Tufts EPO, POS, PPO and Harvard Pilgrim HMO.

3. Proposers must clearly state any restrictions or deviations from these specifications. In the absence of such statement the City shall assume that all items offered are in strict compliance with the technical and financial requirements, and contract terms and conditions described in these specifications. The proposal of the successful proposer will be included as an appendix to the final contract.
4. Enrollees include actives, disabled, COBRA beneficiaries, employees on approved leave of absences, early retirees, and retirees over the age 65 ineligible for Medicare.
5. Actively-at-work requirements and any pre-existing condition exclusions must be waived for current and future participants.
6. Rates should be quoted on a two-tiered basis (i.e. single and family). Any commissions, placement fees, administrative charges or other charges to the City must be included in the rates quoted.
7. The City has a mail order prescription plan as part of its drug program administered by Caremark for Tufts EPO, POS and PPO. Please refer to attachments for plan design.
8. The Harvard Pilgrim Plan offers a mail service prescription drug program administered by Walgreens.
9. Quoted rates should assume the City pays premiums on a monthly basis.
10. Proposals cannot include restrictions or contingencies regarding specific subscribers/members (e.g. those with ongoing claims).
11. Quoted rates will be firm regardless of changes to enrollment for the new plan year.
12. Coverage will provide 100% reimbursement once specific stop-loss levels are reached up to the lifetime maximum.
13. Coverage has no limitations for specific illnesses or physical conditions.
14. All quotes will be considered valid for at least sixty (60) days from the deadline for the submission of the proposals.
15. This bid will be awarded within 60 days of Bid opening.
16. All prices and proposals will be considered final and non-negotiable.

## Vendor Minimum Requirements

In order to be considered an eligible proposer, all respondents must answer "Yes" to the following questions and be prepared to provide supporting documentation as required by the City. In providing responses, proposers must restate the question and provide an answer with supporting information as required.

1) Has the re-insurer been in the reinsurance marketplace for at least five years?

Yes: \_\_\_\_\_

No: \_\_\_\_\_

2) Can the re-insurer verify that it has a record of paying promptly all properly submitted claims?

Yes: \_\_\_\_\_

No: \_\_\_\_\_

3) Can the re-insurer verify that there have been no claims paid late or that have gone unpaid due to insufficiency of funds?

Yes: \_\_\_\_\_

No: \_\_\_\_\_

4) Are all of the re-insurer's sources of financial support (those entities ultimately responsible for guaranteeing the availability of funds to pay claims) rated by a recognizing rating agency (Moody's or A. M. Best, for example)?

Yes: \_\_\_\_\_

No: \_\_\_\_\_

5) Is the re-insurer evaluated by a recognizing rating agency (Moody's or A. M. Best, for example)?

Yes: \_\_\_\_\_

No: \_\_\_\_\_

Date \_\_\_\_\_

\_\_\_\_\_  
(Name of General Bidder)

BY: \_\_\_\_\_

\_\_\_\_\_  
(Printed Name and Title of Signatory)

\_\_\_\_\_  
(Business Address)

\_\_\_\_\_  
(City, State Zip)

\_\_\_\_\_  
(Telephone)

\_\_\_\_\_  
(FAX)

\_\_\_\_\_  
(E-mail Address)



## SELECTION CRITERIA

**Price will not be only criteria upon which the City of Newton makes its selection of reinsurance carrier.** The following criteria will apply:

- ❖ Meets the vendor minimum requirements;
- ❖ Conformance to the specifications of this Request for Proposals including all required contractual provisions specified in Exhibit A, and completeness of responses;
- ❖ Insurance company ratings and claims administration ratings;
- ❖ Price and attractiveness of one-year versus two-year proposal and a attractiveness of specific deductible proposals;
- ❖ Experience and quality of service to clients as reported by Proposer and by References in providing coverage to accounts (including amount of Massachusetts business, dollars paid in stop loss reimbursements, experience in administering policy over multiple carriers/health plans);
- ❖ Turn-around time for reimbursement and availability of immediate reimbursement arrangements;
- ❖ Comprehensiveness and timeliness of reporting to accounts, and general level of service in the above as reported by References;
- ❖ Acceptance of the City of Newton claims administrators: Harvard Pilgrim Health Care, and Tufts Total Health Plan;
- ❖ Status as an admitted carrier in Massachusetts;
- ❖ Demonstrated experience or knowledge of the Massachusetts municipal sector;
- ❖ Stop loss claims tracking, monitoring, and filing capabilities;
- ❖ Demonstration of financial arrangements beneficial to the City of Newton;
- ❖ Optional contract terms which are favorable to the City of Newton.

The above criteria will be applied to proposals to select the policy with the highest value for the City of Newton.

**THIS SPACE INTENTIONALLY LEFT BLANK**

**PROPOSER'S QUESTIONNAIRE**  
**Request for Proposal #14-139**

All Respondents must answer the following questions and requests in writing in order to be considered in the selection process.

**Submit this completed questionnaire with your "Technical Proposal".**  
**Please include additional sheets for your answers if necessary.**

**NAME OF RESPONDING COMPANY AND PROPOSED CARRIER MUST BE ON EACH  
PAGE OF THIS QUESTIONNAIRE.**

**Proposer acknowledges the following addendum: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_**

1. What is the full legal name and address of the entities proposing to provide group medical reinsurance to the City of Newton  
  
Carrier: \_\_\_\_\_  
  
Broker: \_\_\_\_\_  
  
Managing General Underwriter (MGU): \_\_\_\_\_  
  
Stop Loss Administrator: \_\_\_\_\_  
  
Entity responding to this RFP: \_\_\_\_\_
  
2. Is the reinsurance carrier for which you have submitted a proposal an admitted carrier in the Commonwealth of Massachusetts? Yes \_\_\_\_\_; No \_\_\_\_\_
  
3. What is the number of reinsurance contracts in Massachusetts that are currently being placed by the broker named above?  
\_\_\_\_\_  
\_\_\_\_\_
  
4. Describe how your stop-loss charges are calculated.  
\_\_\_\_\_  
\_\_\_\_\_
  
5. Please give assurance that there will be no special underwriting for high cost claimants, i.e. no "lasering" will occur. . And please specify the standards the carrier uses to define "experimental procedures."  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  
6. Describe your process for reimbursement under your contract. Please include and explanation of the process you follow for paying and reviewing claims. How long does reimbursement take after you receive the required documentation?  
\_\_\_\_\_  
\_\_\_\_\_

Name of responding company: \_\_\_\_\_  
Name of proposed carrier: \_\_\_\_\_

7. Describe your liability for specific reimbursement upon contract termination, for both on-and-off anniversary dates.  
\_\_\_\_\_  
\_\_\_\_\_
8. Describe your premium payment procedures and include copies of all applicable forms.  
\_\_\_\_\_  
\_\_\_\_\_
9. Please identify any reimbursement maximums under the proposed specific stop-loss arrangement (e.g., per year, per participant, per contract).  
\_\_\_\_\_  
\_\_\_\_\_
10. Please describe any other limits under your stop-loss agreements (e.g., mental/nervous).  
\_\_\_\_\_  
\_\_\_\_\_
11. Please describe any other funding alternatives or contract forms that you wish to have considered.  
\_\_\_\_\_  
\_\_\_\_\_
12. What was the most recent Standard & Poors, Best, Moody's Duff & Phelps and/or other relevant rating assigned to the reinsurance carrier that you are proposing which demonstrates financial stability, as well as the respective rating which is assigned to the claim paying ability of the carrier? Please provide the date of the rating.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
13. Please provide copies of your specimen contract and any amendments needed to put this contract in conformance with the contractual requirements specified herein.  
\_\_\_\_\_  
\_\_\_\_\_
14. Please provide non-confidential information on reinsurance claims you as Broker/Carrier have paid for Massachusetts clients, for example, total dollar amount paid to Municipalities and School Districts for the past three years, if any.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
15. What is the carrier's average turn-around-time for payment of claims once claims detail has been submitted to the carrier?  
\_\_\_\_\_  
\_\_\_\_\_
16. Does the broker receive compensation other than commissions (i.e. does broker earn fees depending upon the carrier's loss ratio)?  
  
Yes \_\_\_\_\_ No \_\_\_\_\_
17. Please describe the experience the stop loss tracking and filing firm has had in stop loss claims administration.  
\_\_\_\_\_  
\_\_\_\_\_

Name of responding company: \_\_\_\_\_  
Name of proposed carrier: \_\_\_\_\_

18. Will the proposed carrier reimburse the City of Newton based on the basis of payment to the providers used by the claims administrators as opposed to the lesser of charges or basis of payment?

Yes \_\_\_\_\_

No \_\_\_\_\_

19. Do you confirm that the quotations for reinsurance submitted herein are good for 60 days from the due date of proposal?

Yes \_\_\_\_\_

No \_\_\_\_\_

20. Please include the names of five references who can be contacted to comment on your reinsurance coverage. Massachusetts' employers contracting with Tufts Total Health Plan and/or Harvard Pilgrim Health Care are preferred.

\_\_\_\_\_  
\_\_\_\_\_

21. Provide a statement explaining any and all litigation pending against the proposer arising from reinsurance or related services.

\_\_\_\_\_  
\_\_\_\_\_

22. Provide verification that the proposer retains appropriate liability coverage for errors, omissions, and similar occurrences.

\_\_\_\_\_  
\_\_\_\_\_

23. All parties that are assuming risk in reinsurance coverage must be identified. Please provide the party's name, share of the risk, and their level of risk exposure (primary, secondary, etc.).

\_\_\_\_\_  
\_\_\_\_\_

24. Alternative funding arrangements will be considered. Please provide complete details if responding with a non-standard funding approach.

\_\_\_\_\_  
\_\_\_\_\_

25. Sample standard reports and specimen agreements and coverage schedules should be included in your proposal.

\_\_\_\_\_  
\_\_\_\_\_

**By my signature below I certify that the responses provided herein to this Questionnaire of the City of Newton's "Request for Proposals for Group Reinsurance and Reporting" are true and accurate and that materials provided by my company in response to this Request for Proposals are a fair and accurate representation of the proposed reinsurance policy, procedures, and services that will be provided to the City of Newton if accepted.**

\_\_\_\_\_  
(Authorized Representative of Carrier)

\_\_\_\_\_  
(Date)

Name of responding company: \_\_\_\_\_

Name of proposed carrier: \_\_\_\_\_

## CERTIFICATION OF TAX COMPLIANCE

Pursuant to MG c. 62C, § 49A, the undersigned acting on behalf of the Contractor, certifies under the penalties of perjury that, to the best of the undersign's knowledge and belief, the Contractor is in compliance with all laws of the Commonwealth relating to taxes, reporting of employees and contractors, and withholding and remitting child support.\*

\_\_\_\_\_  
\*\*Signature of Individual  
or Corporate Contractor (Mandatory)

\_\_\_\_\_  
\*\*\* Contractor's Social Security Number  
(Voluntary) or Federal Identification Number

By: \_\_\_\_\_  
Corporate Officer  
(Mandatory, if applicable)

Date: \_\_\_\_\_

\* The provision in the Attestation relating to child support applies only when the Contractor is an individual.

\*\* Approval of a contract or other agreement will not be granted unless the applicant signs this certification clause.

\*\*\* Your social security number will be furnished to the Massachusetts Department of Revenue to determine whether you have met tax filing or tax payment obligations. Providers who fail to correct their non-filing or delinquency will not have a contract or other agreement issued, renewed, or extended. This request is made under the authority of GL c. 62C, § 49A.

## **ATTACHMENTS**

ATTACHMENT – A

ATTACHMENT – B

ATTACHMENT – C

ATTACHMENT – D

ATTACHMENT – E

ATTACHMENT – F

ATTACHMENT – G

ATTACHMENT – H

ATTACHMENT – I Census

## **Attachment A – Page 1**

The City of Newton  
For Tufts EPO, POS, PPO and Harvard Pilgrim HMO

Current ReInsurance: (July, 2013 thru June, 2014)	Westport Insurance Corporation through Stop Loss Insurance Brokers
Type of Insurance:	Specific
Attachment Point:	\$250,000
Incurred/Paid:	12 / 18
Individual Rate:	\$8.46 per Month
Family Rate:	\$23.44 per Month
Pre-Existing Exclusions:	None
Waiting Period:	None
Lifetime Maximum:	\$2,000,000
Mental/Nervous Exclusion:	None
Prescription Coverage:	Included





**Attachment B – Page 1**

Tufts Plan  
For City of Newton  
As of May, 2014

**INDIVIDUAL CONTRACTS**

**Subscribers:**

Age Range	Male	Female	Total
0-10	0	0	0
11-20	1	2	2
21-30	60	107	167
31-40	67	96	163
41-50	40	51	91
51-60	44	87	131
61-70	78	155	233
71+	36	60	96

**Members:**

Age Range	Male	Female	Total
0-10	0	0	1
11-20	1	2	2
21-30	60	107	167
31-40	67	96	163
41-50	40	51	91
51-60	44	87	131
61-70	78	155	233
71+	36	60	96

**Attachment B – Page 2**

**Tufts Plan  
For City of Newton  
As of May, 2014**

**FAMILY CONTRACTS**

**Subscribers:**

Age Range	Male	Female	Total
0-10	0	0	0
11-20	0	0	0
21-30	11	18	29
31-40	89	89	178
41-50	117	122	239
51-60	173	167	340
61-70	120	92	212
70+	7	5	12

**Members:**

Age Range	Male	Female	Total
0-10	246	233	479
11-20	283	244	527
21-30	184	216	400
31-40	168	182	350
41-50	217	262	479
51-60	307	334	691
61-70	212	173	352
70+	26	10	39

**Attachment B – Page 3**

**Harvard Pilgrim Plan  
For City of Newton  
As of May, 2014**

**INDIVIDUAL CONTRACTS**

**Subscribers:**

Age Range	Male	Female	Total
0-10	0	0	0
11-20	0	1	1
21-30	61	123	121
31-40	46	87	148
41-50	20	30	48
51-60	29	34	62
61-70	30	57	81
71+	1	8	28

**Members:**

Age Range	Male	Female	Total
0-10	0	0	0
11-20	0	1	1
21-30	61	123	121
31-40	46	87	148
41-50	20	30	48
51-60	29	34	62
61-70	30	57	81
71+	1	8	28

**Attachment B – Page 4**

**Harvard Pilgrim Plan  
For City of Newton  
As of May, 2014**

**FAMILY CONTRACTS**

**Subscribers:**

Age Range	Male	Female	Total
0-10	0	0	0
11-20	0	0	0
21-30	3	15	18
31-40	67	95	162
41-50	70	68	138
51-60	65	72	137
61-70	44	56	100
71+	3	0	3

**Members:**

Age Range	Male	Female	Total
0-10	166	187	353
11-20	153	127	280
21-30	87	110	197
31-40	141	163	304
41-50	127	143	270
51-60	130	136	266
61-70	101	83	184
71+	7	1	8

**Attachment C – Page 1**

FY 11 Claims

Month	Tufts EPO	Individual enrollment	Family enrollment	Tufts POS	Individual enrollment	Family enrollment
July 2010	\$1,518,513.33	733	818	\$420,734.81	189	203
August 2010	\$2,131,312.50	734	829	\$627,021.64	188	202
September 2010	\$1,567,810.88	706	834	\$508,046.47	187	199
October 2010	\$1,673,256.04	698	827	\$496,586.86	186	202
November 2010	\$1,875,281.09	746	838	\$781,130.26	182	207
December 2010	\$1,508,074.67	755	834	\$439,137.39	186	207
January 2011	\$1,508,999.13	760	835	\$543,774.01	187	204
February 2011	\$1,634,474.04	761	837	\$461,396.25	185	207
March 2011	\$1,614,071.84	756	830	\$516,979.27	182	205
April 2011	\$1,678,478.01	753	825	\$470,556.34	181	205
May 2011	\$1,487,092.39	748	817	\$388,821.95	179	205
June 2011	\$1,805,080.92	751	812	\$712,488.18	177	206

FY 12 Claims

Month	Tufts EPO	Individual enrollment	Family enrollment	Tufts POS/PPO	Individual enrollment	Family enrollment
July 2011	\$1,560,717.54	741	816	\$484,392.85	177	205
August 2011	\$1,847,922.89	735	825	\$540,286.03	175	204
September 2011	\$1,391,158.59	702	832	\$461,785.41	166	186
October 2011	\$1,741,589.09	721	844	\$591,762.40	169	187
November 2011	\$1,625,964.10	749	858	\$504,523.04	164	189
December 2011	\$1,254,079.35	743	848	\$473,525.31	159	190
January 2012	\$1,657,857.47	752	877	\$434,789.02	150	169
February 2012	\$1,929,986.62	756	877	\$519,708.97	149	171
March 2012	\$1,650,784.50	754	876	\$474,991.03	146	166
April 2012	\$1,488,389.86	755	876	\$322,048.08	150	161
May 2012		752	873		149	160
June 2012						

**Attachment C – Page 2**

**FY 13 Claims**

Month	Tufts EPO	Individual enrollment	Family enrollment	Tufts POS/PPO	Individual enrollment	Family enrollment
July 2012	\$2,021,957.33	744	883	\$559,251.83	147	148
August 2012	\$1,492,128.59	743	879	\$331,749.82	147	147
September 2012	\$1,541,409.89	705	870	\$421,652.17	141	142
October 2012	\$1,673,824.46	727	873	\$397,471.18	141	141
November 2012	\$1,547,952.57	736	879	\$274,978.99	140	143
December 2012	\$1,825,645.00	752	878	\$422,523.03	138	144
January 2013	\$1,290,494.00	755	878	\$299,743.29	136	140
February 2013	\$1,685,930.50	762	872	\$302,561.53	140	140
March 2013	\$1,716,395.48	761	872	\$391,038.32	141	136
April 2013	\$1,921,022.52	760	868	\$393,080.22	139	136
May 2013	\$1,641,007.81	764	868	\$579,557.37	140	133
June 2013	\$1,682,074.82	762	868	\$489,370.40	138	133

**FY 14 Claims**

Month	Tufts EPO	Individual enrollment	Family enrollment	Tufts POS/PPO	Individual enrollment	Family enrollment
July 2013	\$2,307,578.24	755	875	\$563,289.80	134	130
August 2013	\$1,608,431.06	755	875	\$371,513.36	131	130
September 2013	\$1,984,039.67	745	867	\$493,562.26	126	128
October 2013	\$1,717,001.62	749	872	\$378,416.69	126	126
November 2013	\$1,520,734.33	778	876	\$348,043.01	129	126
December 2013	\$1,905,006.58	772	882	\$475,600.73	129	125
January 2014	\$1,762,176.75	760	882	\$377,830.58	129	125
February 2014	\$1,637,980.25	758	883	\$471,998.10	129	125
March 2014	\$2,939,326.44	762	884	\$432,869.01	128	124
April 2014	\$2,132,177.95	765	885	\$314,248.72	128	122
May 2014		762	883		149	160
June 2014						

**Attachment C – Page 3**

FY11 Claims

Month	Harvard Pilgrim HMO	Individual enrollment	Family enrollment
July 2010	\$1,175,113	593	578
August 2010	\$903,358	583	578
September 2010	\$1,093,552	552	568
October 2010	\$970,600	549	578
November 2010	\$1,509,141	568	580
December 2010	\$1,067,232	570	583
January 2011	\$878,939	568	581
February 2011	\$856,908	567	577
March 2011	\$1,312,472	559	571
April 2011	\$1,039,786	552	571
May 2011	\$845,554.84	549	570
June 2011	\$1,040,043.44	549	566

FY12 Claims

Month	Harvard Pilgrim HMO	Individual enrollment	Family enrollment
July 2011	\$920,285.98	549	566
August 2011	\$1,108,422.09	549	566
September 2011	\$617,807.04	497	566
October 2011	\$796,635.59	496	551
November 2011	\$1,122,533.10	496	557
December 2011	\$862,525.73	502	556
January 2012	\$532,792.73	494	554
February 2012	\$980,132.86	489	551
March 2012	\$872,165.70	489	549
April 2012	\$827,203.60	487	548
May 2012	\$1,102,025.08	485	550
June 2012	\$1,126,038.43	479	553

**Attachment C – Page 4**

FY13 Claims

Month	Harvard Pilgrim HMO	Individual enrollment	Family enrollment
July 2012	\$1,073,240.55	474	560
August 2012	\$1,058,500.10	473	562
September 2012	\$1,093,552.37	431	552
October 2012	\$1,143,920.13	465	555
November 2012	\$800,784.76	489	558
December 2012	\$862,333.93	493	557
January 2013	\$883,984.60	497	556
February 2013	\$976,523.41	491	556
March 2013	\$896,060.57	489	554
April 2013	\$991,130.91	490	554
May 2013	\$998,291.65	491	562
June 2013	\$891,232.34	496	560

FY14 Claims

Month	Harvard Pilgrim HMO	Individual enrollment	Family enrollment
July 2013	\$1,622,308.31	495	560
August 2013	\$999,598.42	494	559
September 2013	\$1,108,959.86	472	550
October 2013	\$1,144,150.26	482	560
November 2013	\$884,650.62	520	564
December 2013	\$994,977.41	534	565
January 2014	\$812,227.04	534	560
February 2014	\$989,746.87	532	557
March 2014	\$1,028,595.56	527	559
April 2014	\$1,218,847.12	527	558
May 2014		529	557
June 2014			



**Attachment D – Page 1**

City of Newton  
Tufts Total Health – Payments in excess of \$100,000  
July 1, 2010 through June 30, 2011

Sex	Relation	Payment	Plan	Current Status	Diagnosis	Prognosis	DOB
F	S	\$180,642	EPO	Active	Diverticulitis of Colon	Stable	11/22/1950
F	M	\$115,458	POS	Active	Enc Antineoplastic Chemo	Stable	2/7/1950
F	M	\$268,197	POS	Active	Reg Enterit SM/LG Intest	Stable	9/19/1968
M	S	\$179,113	POS	Active	Mitral Valve Disorder	Stable	10/10/1949
M	S	\$114,137	EPO	Active	Subendo Initial Episode	Stable	11/10/1929
F	S	\$121,015	POS	Active	Mitral Valve Disorder	Stable	7/2/1946
F	S	\$101,126	EPO	Active	Occl & Sten W Cereb Infa	Stable	12/12/1936
F	M	\$135,764	EPO	Active	Benign Neo Cranial Nerve	Stable	6/10/1957
F	S	\$115,784	EPO	Active	Enc Antineoplastic Chemo	Stable	7/1/1945
M	M	\$116,352	EPO	Active	Acute & Chronice Resp Fai	Stable	12/5/1945
F	S	\$206,817	EPO	Termed	Enc Antineoplastic Chemo		10/20/1951
F	S	\$221,258	POS	Active	Staphylococcus Aureus Se	Stable	4/21/1946
F	S	\$159,372	EPO	Active	Enc Antineoplastic Chemo	Stable	12/16/1953

**Attachment D – Page 2**

Tufts Total Health – Payments in excess of \$100,000  
July 1, 2011 through June 30, 2012

Sex	Relation	Payment	Plan	Current Status	Diagnosis	Prognosis
M	S	\$177,317	POS	Active	Strep pneumonia NEC	Stable
F	S	\$107,827	POS	Active	Rehabilitation px NEC	Stable
F	M	\$182,296	POS	Termed	Hemoperitoneum	
F	M	\$157,909	EPO	Termed	Recurrent MDD- unspec	
F	M	\$248,801	Multiple	Active	Female breast CA NOS	Stable
M	M	\$161, 224	Multiple	Termed	Abd aortic aneurysm	
F	S	\$164,306	EPO	Active	Non-healing surg WND	Stable
F	M	\$118,791	Multiple	Active	Female breast CA NOS	Stable
M	S	\$161,236	EPO	Active	Ben cereb meningitis neopl	Minimal needs
M	S	\$182,018	EPO	Active	Radiotherapy encounter	Same
F	S	\$112,292	EPO	Termed	Female UOQ breast CA	
F	S	\$161,611	Multiple	Active	Antineo chemo encounter	Same
F	S	\$105,125	EPO	Termed	Antineo chemo encounter	

**Attachment D – Page 3**

Tufts Total Health – Payments in excess of \$100,000  
July 1, 2012 through June 30, 2013

Sex	Relation	Payment	Plan	Current Status	Diagnosis	Prognosis
M	S	\$100,427	EPO	Active	Xnodal/NOS lymphoma NEC	Same
F	M	\$113,694	POS	Active	Rx; Atrial fibrillation	Stable
F	S	\$118,980	EPO	Active	Fx dorsal vertebra – close	Same
F	M	\$143,355	Multiple	Termed	Depressive disorder NEC	
F	S	\$135,610	POS	Termed	Fracture two ribs – closed	
M	S	\$392,842	EPO	Termed	Fx C5 vertebra – closed	
F	S	\$123,628	EPO	Active	Recrosigmoid junction CA	Stable
F	S	\$133,488	EPO	Active	Pancreas CA NOS	Stable
F	M	\$167,703	EPO	Active	Female UOQ breast CA	Stable
M	M	\$186,542	EPO	Active	Ventricular fibrillation	Stable
M	M	\$130,950	PPO	Active	Recurrent MDD – severe	Stable
M	S	\$367,716	EPO	Active	Male breast CA NEC & NOS	Stable
F	S	\$132,822	POS	Active	Atrial fibrillation	Minimal needs
F	S	\$189,073	EPO	Active	Female breast CA NOS	Stable
F	S	\$105,256	POS	Active	Oth cardiac dysrhythmias	Stable

**Attachment D – Page 4**

Tufts Total Health – Payments in excess of \$100,000  
July 1, 2013 through April 30, 2014

Sex	Relation	Payment	Plan	Current Status	Diagnosis	Prognosis
M	S	\$225,703	POS	Active	Staph septicemia NEC	Same
M	S	\$113,541	EPO	Active	Thoracic esophagus CA	Stable
F	S	\$103,224	POS	Active	Vasc insuff intest NOS	Stable
M	S	\$299,392	EPO	Active	Septicemia NOS	Stable
F	S	\$138,227	EPO	Active	Up lob bronchus/lung CA	Stable
F	S	\$135,954	POS	Active	Pyogen arthritis- pelvis	Stable
M	S	\$107,636	EPO	Active	Cor AS – native vessel	Stable
M	S	\$483,825	EPO	Active	Septicemia NOS	Stable
F	M	\$131,432	EPO	Active	Post-mastectomy reconst	Stable
M	S	\$126,735	EPO	Active	Amyloidosis NEC	Stable
F	S	\$110,429	POS	Active	MG w/o exacerbation	Same
M	M	\$176,037	EPO	Active	Infect D/T orth dev NEC	Stable
F	S	\$106,015	EPO	Active	Viral hepatitis vaccine	Stable
M	S	\$271,894	EPO	Active	Male breast CA NEC & NOS	Stable
M	S	\$125,370	POS	Active	Aortic valve disorder	Same
F	S	\$133,308	EPO	Active	Female breast CA NOS	Stable
F	M	\$196,508	PPO	Active	Multiple sclerosis	Same
F	S	\$139,130	EPO	Active	ImmunoTx encount neopl	Stable
F	S	\$151,620	EPO	Active	Low lob bronch/lung CA	Same
F	S	\$103,773	EPO	Termed	Septicemia NOS	
F	M	\$385,429	EPO	Active	Extreme immature 750-999g	Stable

**Attachment D – Page 5**

Cutoff Amount : 100,000  
Cost Logic: CU / Cost and Utilization Paid Logic  
Incurred Period: 2010-07-01 to: 2011-06-30  
Paid Period: 2010-07-01 to: 2011-03-31  
Group/Division Numbers: 065710 / All Divisions  
*Harvard Pilgrim Health Care*

Claimant 1	Injury and Poisoning	Active	\$241,468.53
Claimant 2	Diseases of the Circulatory System	Active	\$171,852.92
Claimant 3	Diseases of the Circulatory System	Active	\$133,181.78
Claimant 4	Endocrine, Nutritional, and Metabolic Diseases And Immunity Disorders	Active	\$130,531.04
Claimant 5	Diseases of the Nervous Systems and Sense Organs	Active	\$126,679.22

Cutoff Amount : 100,000  
Cost Logic: CU / Cost and Utilization Paid Logic  
Incurred Period: 2011-07-01 to: 2012-06-30  
Paid Period: 2011-07-01 to: 2014-02-28  
Group/Division Numbers: 065710 / All Divisions  
*Harvard Pilgrim Health Care*

Claimant 1	Certain Causes of Perinatal Morbidity and Mortality	Active	\$460,706.61
Claimant 2	Classification of Factors Influencing Health Status and Contact w/Health Service	Active	\$333,506.62
Claimant 3	Diseases of the Digestive System	Active	\$301,970.16
Claimant 4	Injury and Poisoning	Active	\$252,409.27
Claimant 5	Diseases of the Circulatory System	Active	\$237,104.28
Claimant 6	Diseases of the Digestive System	Active	\$153,883.52
Claimant 7	Injury and Poisoning	Active	\$106,379.98
Claimant 8	Diseases of the Nervous System and Sense Organs	Active	\$105,184.12

**Attachment D – Page 6**

Cutoff Amount : 100,000  
Cost Logic: CU / Cost and Utilization Paid Logic  
Incurred Period: 2012-07-01 to: 2013-06-30  
Paid Period: 2012-07-01 to: 2014-02-28  
Group/Division Numbers: 065710 / All Divisions  
*Harvard Pilgrim Health Care*

Claimant 1	Infectious and Parasitic Diseases	Active	\$395,393.54
Claimant 2	Neoplasms	Active	\$366,659.23
Claimant 3	Diseases of the Digestive System	Active	\$266,092.89
Claimant 4	Diseases of the Genitourinary System	Active	\$209,430.67
Claimant 5	Diseases of the Genitourinary System	Active	\$150,924.23
Claimant 6	Diseases of the Musculoskeletal System and Connective Tissue	Active	\$129,435.86
Claimant 7	Diseases of the Nervous System and Sense Organs	Active	\$124,081.48
Claimant 8	Neoplasms	Active	\$122,877.31
Claimant 9	Diseases of the Digestive System	Active	\$105,596.40
Claimant 10	Diseases of the Digestive System	Active	\$103,162.82
Claimant 11	Neoplasms	Active	\$101,977.90

Cutoff Amount : 100,000  
Cost Logic: CU / Cost and Utilization Paid Logic  
Incurred Period: 2013-07-01 to: 2014-02-28  
Paid Period: 2013-07-01 to: 2014-04-30  
Group/Division Numbers: 065710 / All Divisions  
*Harvard Pilgrim Health Care*

Claimant 1	Injury and Poisoning	Active	\$249,534.62
Claimant 2	Neoplasms	Active	\$219,286.90
Claimant 3	Injury and Poisoning	Active	\$149,036.23
Claimant 4	Neoplasms	Active	\$139,893.84
Claimant 5	Neoplasms	Active	\$138,086.87
Claimant 6	Diseases of the Circulatory	Active	\$106,639.11

**Schedule of Benefits**  
**The Harvard Pilgrim HMO**  
Services listed are covered when medically necessary  
and provided or arranged by Harvard Pilgrim Health Care Providers.  
Please see your Benefit Handbook for details.

D6

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**Inpatient Acute Hospital Services (including day surgery)**

All covered services including the following:

- Coronary care
- Hospital services
- Intensive care
- Physicians' and surgeons' services including consultations
- Semi-private room and board

*Subject to hospital inpatient copayment+.*

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**Hospital Outpatient Department Services**

- Anesthesia services
- Endoscopic procedures
- Laboratory tests and x-rays
- Physicians' and surgeons' services
- Chemotherapy/Radiation therapy

*Covered in full*

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**Physician services (including covered services by a podiatrist)**

- Chemotherapy
- Changes and removals of casts, dressings, or sutures
- Health education including nutritional counseling
- Preventive care including routine physical examinations, immunizations, annual eye examinations, school, camp, sports, and premarital examinations
- Vision and hearing screenings
- Administration of injections/Allergy tests and treatments
- Diagnostic screening and tests, including but not limited to mammograms, blood tests and screenings mandated by state law
- Sick and well office visits, including psychopharmacological services

*\$15 copayment per visit. (Please note: diagnostic tests, mammograms, x-rays, and immunizations will be covered in full if billed without an office visit and no other services are provided.)*

- Administration of allergy injections

*\$5 copayment per visit.*

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**Maternity Services**

- Prenatal and postpartum care
- All hospital services for mother and routine nursery charges for newborn

*Subject to hospital inpatient copayment+.*

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**Mental Health and Drug and Alcohol Rehabilitation Services**

Please note that no day or visit limits apply to inpatient or outpatient mental health treatment for biologically-based mental disorders, rape-related mental or emotional disorders, and non-biologically-based mental, behavioral or emotional disorders for children and adolescents. No day or visit limits apply to inpatient or outpatient drug and alcohol rehabilitation services that are authorized by an HPHC mental health clinician in conjunction with treatment of mental disorders. (Please see your Benefit Handbook for details.)

- Outpatient mental health services

*Covered up to 24 visits per calendar year for individual therapy and 25 visits per calendar year for group therapy with a combined maximum not to exceed 25 individual and group therapy visits per calendar year. \$15 copayment per visit for individual therapy visits 1-24. \$10 copayment per visit for group therapy visits 1-25.*

- Outpatient drug and alcohol rehabilitation services

*Covered up to 20 visits or \$500 in benefit value, whichever is greater. \$15 copayment per visit for individual therapy visits 1-8. \$25 copayment per visit for individual therapy visits after 8. \$10 copayment per visit for group therapy visits.*

- Psychological testing

*\$15 copayment per visit.*

- Inpatient mental health services

*Subject to hospital inpatient copayment+ in a licensed general hospital.*

*Subject to hospital inpatient copayment+, up to 60 days per member per calendar year in a psychiatric hospital.\**

- Inpatient drug and alcohol rehabilitation services

*Subject to hospital inpatient copayment+, up to 30 days per member per calendar year.\**

- Detoxification

*Subject to hospital inpatient copayment+ for inpatient services. \$15 copayment per visit for outpatient services.*

\*Note: Partial hospitalization services are available up to a maximum of 120 days per calendar year in place of inpatient mental health services. Partial hospitalization services are available up to a maximum of 60 days per calendar year in place of inpatient drug and alcohol rehabilitation services.



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**Home Health Care Services**

- Home care services
- Intermittent skilled nursing care

*Covered in full*

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**Dental Services**

- Preventive care for children under the age of 14. Two visits per member per calendar year including examination, cleaning, x-rays and fluoride treatment.

*Covered in full*

- Initial emergency treatment (within 72 hours of injury) necessary to repair oral injuries including x-rays, surgical procedures, extractions, and suturing
- Extraction of impacted teeth

*The applicable copayment will be determined by location of service.*

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**Emergency Services**

- You are always covered for care in a Medical Emergency. A referral from your PCP is not needed. In a Medical Emergency, you should go to the nearest emergency facility or call 911 or other local emergency number. If you are hospitalized, you must call your PCP within 48 hours, or as soon as you can. Please note that this requirement is met if your attending physician has already given notice to your PCP.

*\$50 copayment per visit in the emergency room or a \$15 copayment per visit in a doctor's office or hospital outpatient department. This copayment is waived if admitted directly to the hospital from the emergency room.*

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**Skilled Nursing Care and Inpatient Rehabilitation**

- Room and board, special services and physicians' services

*100 days per calendar year at a semi-private rate for each benefit, subject to hospital inpatient copayment. +*

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**Other Health Services**

- Ambulance services
- Low protein foods (\$2,500 per member per calendar year)
- State mandated formulas
- Lead testing

*Covered in full*

- Vision Hardware for special conditions

*Covered in full up to the applicable benefit limits as described in the Benefit Handbook.*

- Cardiac rehabilitation
- Dialysis
- Family planning services/Infertility services
- Medical treatment of temporomandibular joint dysfunction (TMJ)
- Speech-language and hearing services including therapy
- Physical and occupational therapies - up to 90 consecutive days per condition
- House calls by a physician

*\$15 copayment per visit.*

- Hospice services
- Human organ transplants
- Cosmetic surgery as described in the Benefit Handbook

*The applicable copayment will be determined by location of service.*

- Durable medical and prosthetic equipment (including ostomy supplies)

*Covered in full after a copayment of 20% of the equipment cost to HPHC, not to exceed a Member's total expense of \$1,000. There is no coverage after \$5,000 in equipment costs have been paid, including Member copayments. Included in this benefit is coverage for wigs, up to \$350 per member per calendar year when needed as a result of any form of cancer or leukemia, alopecia areata, alopecia totalis or permanent hair loss due to injury.*

- Diabetes equipment and supplies

*Molded shoes and inserts; dosage gauges; injectors; lancet devices; voice synthesizers and visual magnifying aids are subject to the applicable copayment under the durable medical and prosthetic equipment benefit.*

*Blood glucose monitors, insulin pumps and infusion devices are covered in full.*

*Insulin; insulin syringes; insulin pump supplies; insulin pens with insulin; lancets; oral agents for controlling blood sugar; blood test strips; and glucose, ketone and urine test strips are covered in full after the applicable prescription drug copayment listed on your ID card, if your Employer Group has selected prescription drug coverage. If prescription drug coverage is not available, then you will pay a \$5 copayment for Generic items, a \$10 copayment for Select Brand items and a \$25 copayment for Non-Select Brand items.*

- Early intervention services

*\$15 copayment per visit up to a maximum of \$3,200 per member per calendar year and a lifetime maximum of \$9,600.*

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**Special Enrollment Rights**

If an employee declines enrollment for the employee and his or her dependents (including his or her spouse) because of other health insurance coverage, the employee may be able to enroll in this plan in the future along with his or her dependents, provided that enrollment is requested within 30 days after other coverage ends. In addition, if the employee has a new dependent as a result of marriage, birth, adoption or placement for adoption, the employee may be able to enroll along with his or her dependents, provided that enrollment is requested within 30 days after the marriage, birth, adoption or placement for adoption.

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## Membership Requirements

There are a few requirements that you must meet in order to be covered by the plan. (Please see your Benefit Handbook for a complete description).

- Members must live in the Plan's Enrollment Area for at least nine months of the year. An exception is made for full-time student dependents and dependents enrolled under a Qualified Medical Support Order.
- All your medical and health care needs must be provided or arranged by your primary care physician (PCP), except in a medical emergency, when you are temporarily outside the Plan Service Area, or when you need one of the special services which do not require a referral. The Plan Service Area is the state in which you live.

## Annual Out-of-Pocket Maximums

- The total maximum copayments you will be required to pay for all covered services excluding riders (e.g. prescription drugs, adult preventive dental and vision hardware) shall not exceed \$2,000 per Member per calendar year or a total of \$4,000 per Family per calendar year. The Plan will notify you if you reach these limits. If you feel that you reached these limits, but have not been notified, please contact the Plan.

## + Inpatient Copayment

- Hospital Inpatient Copayment: \$150 per admission up to an aggregate maximum of \$300 per contract per calendar year. Day Surgery is covered in full.

## Exclusions

The Plan does not provide coverage for:

- services not approved, arranged, or provided by your PCP
- cosmetic procedures
- commercial diet plans or weight loss programs
- transsexual surgery, including related procedures
- procedures which are experimental or unproven
- eyeglasses, contact lenses, and fittings, unless your Employer Group has purchased the Vision Rider
- refractive eye surgery
- transportation other than by ambulance
- costs for any services for which you are entitled to treatment at government expense, including military service connected disabilities
- costs for services covered by workers' compensation, third party liability, other insurance coverage, or an employer under state or federal law
- blood and blood products
- educational services (including problems of school performance) or testing for developmental, educational, or behavioral problems
- sensory integrative praxis tests
- physical examinations for insurance, licensing, or employment
- vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation
- rest or custodial care
- personal comfort or convenience items
- non-durable medical equipment, unless used as a part of the treatment at a medical facility or as part of approved home health care services

- reversal of voluntary sterilization (including procedures necessary for conception as a result of voluntary sterilization) and any form of surrogacy
- infertility treatment for Members who are not medically infertile
- delivery outside the service area after the 37th week of pregnancy, or after you have been told that you are at risk for early delivery
- special equipment needed for sports or occupational purposes
- services for which no charge would be made in the absence of insurance
- services for non-Members
- services after the termination of membership
- services or supplies given to you by 1) anyone related to you by blood, marriage, or adoption, or, 2) anyone who ordinarily lives with you
- services that are not medically necessary
- services for which no coverage is provided in the Benefit Handbook, Schedule of Benefits, or Prescription Drug Brochure
- hearing aids
- foot orthotics, except as required by law
- dental services including periodontal, restorative, and orthodontic services
- chiropractic care
- osteopathic manipulation, routine foot care, biofeedback, pain management programs, massage therapy, acupuncture, and sports medicine clinics
- hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy

## SUMMARY OF BENEFITS

Effective December 1, 2003

Outpatient Medical Care	Unauthorized Benefits Only
Doctor's Office Visits	\$15 per visit
Routine Physical Exams	\$15 per visit
Well-Child Care	\$15 per visit
Specialist Care, Consultations	\$15 per visit
OB/GYN visits	\$15 per visit
Prenatal and Postnatal Care	\$15 per visit
Laboratory Tests, including Pap Smear	Covered in Full
Diagnostic X-rays, including Mammograms	Covered in Full
Injections and Immunizations	Covered in Full
X-ray Therapy	Covered in Full
Speech Therapy and Short-term Physical/Occupational Therapy	\$15 per visit
Annual Routine Eye Exams	\$15 per visit
Spinal Manipulation (12 visits per calendar year)	\$15 per visit

Inpatient Hospital Care and Surgery*	
Day Surgery	\$0 per surgery
Acute care for Illness or Injury, and Maternity Services	\$150 per admission
Physician's Care while hospitalized	Covered in Full
Surgery and Surgeon's Services while hospitalized	Covered in Full
Newborn Care in hospital	Covered in Full
Anesthesia while hospitalized	Covered in Full
Medications while hospitalized	Covered in Full
Nursing Care while hospitalized	Covered in Full
X-ray and Lab Services while hospitalized	Covered in Full
Intensive Care/Coronary Care while hospitalized	Covered in Full
Radiation Therapy while hospitalized	Covered in Full
Skilled Nursing In Skilled Nursing Facility (up to 100 days per calendar year)	Covered in Full

Wellness Programs	
Membership at Network Fitness Facilities	Multiple discount options
Weight Watchers Weight Management Program	Discounted membership
Health Education (may require advance payment)	30% discount per program

\* Semi-private room, unless private room is medically necessary.

(OVER)

**Mental Health\***

Outpatient Care (up to 24 visits per calendar year)	\$15 per visit
Inpatient Care (Services provided through a Designated Facility Program for up to 60 days per calendar year)	\$150 per admission

**Substance Abuse\*\***

Outpatient Care (Alcohol, Drug and Detoxification) (Covered up to \$500 per calendar year)	\$15 per visit
Inpatient Care (Services provided through a Designated Facility Program for up to 30 days per calendar year)	\$150 per admission

**Emergency Care**

In Doctor's Office	\$15 per visit
In Emergency Room	\$50 per visit

**Other Services**

Durable Medical Equipment (\$5,000 calendar year maximum)	Plan pays 80%; Member pays 20%
Ambulance (when medically necessary)	Covered in Full

**Inpatient Out-of-Pocket Maximum**

Annual Individual Out-of-Pocket Maximum	\$300
Annual Family Out-of-Pocket Maximum***	\$300

\* As required by law, coverage for certain mental health disorders is the same as for other medical conditions. See your member benefit document for more information.

\*\* Treatment for detoxification is not subject to substance abuse day and visit limits listed in this document. See your member benefit document for more information.

\*\*\* No more than two inpatient copayments will apply to each family. Maximums will be administered by City of Newton.

There are some services that the plan does not cover. These include, but are not limited to: A service or supply not described as covered in the member's benefit document • Exams required by a third party, such as your employer, an insurance company, school or court • Any tax, surcharge, assessment or other similar fee imposed under any state or federal law or regulation on any provider, member, service, supply or medication • Cosmetic surgery or any other cosmetic procedure except certain reconstructive procedures • Experimental or investigational drugs, services and procedures • Eyeglasses or contact lenses • Whole blood, packed red blood cells and blood donor fees • Drugs for use outside of hospital except as covered under Prescription Drug Coverage • Personal comfort items • Custodial care • A service furnished to someone other than the member • Routine foot care • Charges incurred for stays in a covered facility beyond the discharge hour • Care for conditions that state or local law requires to be treated in public facility • Medical or surgical procedures for sexual reassignment and reversal of voluntary sterilization • Long-term (more than 60 days) outpatient physical and occupational therapy services • Foot orthotics • Assisted reproductive technology (e.g. IVF) procedures for non-Massachusetts residents

*This is a summary only. Please refer to your member benefit document for more detailed information.  
Copies are available through your employer.*

**Administered by Total Health Plan, Inc., A Tufts Health Plan company.**

Value EPO C



# POS VALUE SUMMARY OF BENEFITS

Tufts Health Plan's point-of-service (POS) plan covers preventive and medically necessary health care services and supplies.

As a POS member, you can choose between two levels of coverage:

- **Coverage at the authorized level of benefits, a higher level of coverage**, when care is provided or authorized by your primary care physician (PCP) in the Tufts Health Plan network. You pay a copayment at the time you receive covered health care services.
- **Coverage at the unauthorized level of benefits**, when covered health care services are not provided or authorized by your Tufts Health Plan PCP. You pay a deductible and coinsurance when you obtain care at the unauthorized level of benefits.
  - **A deductible** is the amount you must pay out of pocket before any coverage is available at the unauthorized level of benefits.

**TUFTS**  **Health Plan**

*No one does more to keep you healthy.*

- Once you have paid the deductible, you pay **coinsurance**--a percentage of the covered medical costs you are responsible for paying at the unauthorized level of benefits--until you reach the **out-of-pocket maximum**.
- Once you reach the out-of-pocket maximum, you are covered in full up to the reasonable charge for most out-of-network covered services for the remainder of the plan (usually a plan year).
- To be reimbursed for covered services at the unauthorized level of benefits, you may need to submit a claim form. You may be responsible for paying any difference between what the plan covers and what the out-of-network provider charges for a service.
- Emergency care is covered at the authorized level of benefits, regardless of whether you see an in-network or out-of-network provider.

The deductible and out-of-pocket maximum for this plan are listed on this benefit summary.

 This health plan meets Minimum Creditable Coverage standards and will satisfy the individual mandate that you have health insurance.

Prescription Drug Coverage		For up to a 30-day supply at a participating retail pharmacy	For up to a 90-day supply through our mail order service
Tier 1		\$5	\$10
Tier 2		\$20	\$40
Tier 3		\$30	\$60
Deductible and Out-of-pocket Maximums (per plan year)		Individual	Family
Deductible (applies to unauthorized care only)		\$250	\$500
Out-of-pocket maximum (includes deductible and coinsurance)		\$1,000	\$15,000
Inpatient copayment maximum (No more than two inpatient copayments will apply to each family. Maximums will be administered by the City of Newton)		\$300	\$300
Outpatient Medical Care (No PCP referral is necessary for OB/GYN visits, spinal manipulation, routine eye exams, or mammograms)		Authorized	Unauthorized (after deductible)
Most Provider Office Visits		\$15 per visit	Plan covers 80%
Routine Physical Exams (including most preventive screenings)		\$15 per visit	Plan covers 80%
Well-Child Care		\$15 per visit	Plan covers 80%
OB/GYN Visits		\$15 per visit	Plan covers 80%
Outpatient Maternity Care (This office visit copayment will apply per visit up to 10 visits per pregnancy. After 10 visits, these services are covered in full for the remainder of your pregnancy.)		\$15 per visit	Plan covers 80%
Routine Eye Exams (1 visit every 12 months)		\$15 per visit	Plan covers 80%
Nutritional Counseling (When medically necessary)		\$15 per visit	Plan covers 80%
Preventive Immunizations		Covered in full	Plan covers 80%
Preventive Pap Smears and Mammograms		Covered in full	Plan covers 80%
Non-preventive Immunizations		Covered in full	Plan covers 80%
Non-routine Pap Smears and Mammograms		Covered in full	Plan covers 80%
Allergy Injections		Copay may apply	Plan covers 80%
Diagnostic Procedures		Covered in full	Plan covers 80%
Diagnostic Imaging - General Imaging (such as X-rays and ultrasounds)		Covered in full	Plan covers 80%
Diagnostic Imaging - High-Tech Imaging (MRIs, CT/CAT Scans, PET Scans, and Nuclear Cardiology)		Covered in full	Plan covers 80%
Diagnostic Lab Tests		Covered in full	Plan covers 80%
Speech and Short-term Physical/Occupational Therapy		\$15 per visit	Plan covers 80%
Spinal Manipulation (12 visits per plan year)		\$15 per visit	Plan covers 80%
Day Surgery		Covered in full	Plan covers 80%

<b>Inpatient Hospital Care</b> (Semi-private room, unless private room is medically necessary)	Authorized	Unauthorized (after deductible)
All Hospital Services (Acute Care) and Maternity Care	\$150 per admission	Plan covers 80%
Skilled Nursing in Skilled Nursing Facility (up to 100 days per plan year)	Covered in full	Plan covers 80%
<b>Emergency Care</b>		
In Doctor's Office	\$15 per visit	
In Emergency Room	\$50 per visit	
<b>Mental Health*</b>	Authorized	Unauthorized (after deductible)
Outpatient Care (up to 30 visits per plan year)	\$15 per visit	Plan covers 80%
Inpatient Care (Services provided at a designated facility for up to 60 days per plan year)	Error! Not a valid link. per admission	Plan covers 80%
<b>Substance Abuse**</b>	Authorized	Unauthorized (after deductible)
Outpatient Care (Alcohol and drug treatment, detoxification) (Up to \$500 per plan year for treatment)	\$15 per visit	Plan covers 80%
Inpatient Care (Services provided at a designated facility for up to 30 days per plan year)	Error! Not a valid link. per admission	Plan covers 80%
<b>Other Health Services</b>	Authorized	Unauthorized (after deductible)
Durable Medical Equipment	Covered in full	Plan covers 80%
Ambulance Service	Covered in full	Plan covers 80%
Hospice Care	Covered in full	Plan covers 80%
Home Health Care	Covered in full	Plan covers 80%
Pediatric Dental: X-Rays (full mouth) once every 5 years. Bitewings, once every 6 months and periapicals as needed. Periodic oral exam, oral prophylaxis and fluoride treatment once every 6 months.	Covered for children under 12	Not covered
<b>Great Savings While You Get Healthy</b> In addition to your covered benefits, we offer great savings on a wide variety of healthy products, services, and treatments—from acupuncture and massage therapy to wellness programs. You save while you're taking care of your health. That's a real win-win! To learn more, visit <a href="http://www.tuftshealthplan.com">www.tuftshealthplan.com</a> and click on Discounts on the Members tab. Regular exercise is an important part of living a healthy lifestyle, and we want to do whatever we can to help you and your family incorporate activity into your daily lives. That's why <b>your Tufts Health Plan membership includes a \$150 rebate per household toward your health and fitness club fees.</b> See the fitness reimbursement flyer in your member enrollment kit for more information.		

\*Outpatient and inpatient mental health services are treated the same as any other medical condition when provided as required by law for the following: biologically-based mental disorders; certain mental, behavioral or emotional disorders for children under age 19; and rape-related mental or emotional disorders. See your Tufts Health Plan member benefit document for more information.

\*\*Outpatient and inpatient substance abuse services are treated the same as mental health conditions when provided in conjunction with treatment of a mental disorder. Treatment for detoxification is not subject to substance abuse day and dollar limits listed in this document. See your Tufts Health Plan member benefit document for more information.

**There are some services that the plan does not cover.** These include, but are not limited to: A service or supply not described as a covered service in your Tufts Health Plan member benefit document • Exams required by a third party, such as your employer, an insurance company, school, or court • Cosmetic surgery or any other cosmetic procedure, except certain reconstructive procedures described in your Tufts Health Plan member benefit document • Experimental or investigational drugs, services, and procedures • Eyeglasses or contact lenses, except as described in your Tufts Health Plan member benefit document • Blood, blood donor fees, blood storage fees, blood substitutes, blood banking, cord blood banking, or blood products, except as described in your Tufts Health Plan member benefit document • Drugs for use outside of hospital, except as covered under Prescription Drug Coverage • Personal comfort items • Custodial care • A service furnished to someone other than the member • Routine foot care, except as described in your Tufts Health Plan member benefit document • Charges incurred for stays in a covered facility beyond the discharge hour • Care for conditions that state or local law requires to be treated in a public facility • Medical or surgical procedures for sexual reassignment and reversal of voluntary sterilization • Foot orthotics, except therapeutic/molded shoes for an individual with severe diabetic foot disease • Assisted reproductive technology (e.g. IVF) procedures for non-Massachusetts residents • Spinal manipulation services for members age 12 and under • Except for Emergency care, a service, supply or medication that is obtained outside of the 50 United States • Private duty nursing (block or non-intermittent nursing) • Hearing aids.

This is a summary only. Please refer to the member benefit document for a detailed explanation of your coverage. If there is a difference between the information in this benefit summary and your member benefit document, the terms of your member benefit document will govern. If you have additional questions, please call a member services specialist at 1-800-462-0224.

Offered by Tufts Associated Health Maintenance Organization, Inc. or Total Health Plan, Inc., both Tufts Health Plan companies.

Massachusetts Requirement to Purchase Health Insurance: As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector Web site ([www.mahealthconnector.org](http://www.mahealthconnector.org)). This health plan meets Minimum Creditable Coverage standards that are effective January 1, 2009 as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you will satisfy the statutory requirement that you have health insurance meeting these standards. This disclosure is for minimum creditable coverage standards that are effective January 1, 2009. Because these standards may change, review your health plan material each year to determine whether your plan meets the latest standards. If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its Web site at [www.mass.gov/doi](http://www.mass.gov/doi)



# **EPO VALUE SUMMARY OF BENEFITS**

With Tufts Health Plan's EPO (exclusive provider option) plan, you enjoy comprehensive coverage for your health care needs, while your out-of-pocket costs are kept to a minimum.

In general, preventive and medically necessary health care services and supplies are covered when they are provided or authorized by your network primary care physician (PCP).

As an EPO member:

- You must choose a PCP from the Tufts Health Plan network of providers.
- In most cases, your PCP must provide or authorize (provide a referral for) your care.
- You pay the applicable copayment at the time you receive covered health care services. There are annual maximums on the number or amount of copayments you pay for day surgery and inpatient care. Please check this benefit summary for more information.

EPO members do not need a PCP referral for certain types of covered services, including:

- Maternity care and medically necessary evaluations and related health care services for acute/emergency gynecologic conditions, when the services are provided by an obstetrician, gynecologist, certified nurse midwife, or family practitioner in the Tufts Health Plan network
- Routine gynecologic exams and any medically necessary OB/GYN follow-up care resulting from that exam, when obtained from a provider in the Tufts Health Plan network
- Emergency care in an emergency room or a physician's office
- Mammography screening, when obtained from a provider in the Tufts Health Plan network
- One routine eye exam every 12 months, when provided by a network physician, if your plan offers this benefit





## ATTACHMENT - E

 This health plan meets Minimum Creditable Coverage standards and will satisfy the individual mandate that you have health insurance.

Prescription Drug Coverage		For up to a 30-day supply at a participating retail pharmacy	For up to a 90-day supply through our mail order service
Tier 1		\$5	\$10
Tier 2		\$20	\$40
Tier 3		\$30	\$60
Out-of-Pocket Maximums (per plan year)		Individual	Family
Inpatient copayment maximum (No more than two inpatient copayments will apply to each family. Maximums will be administered by the City of Newton)		\$300	\$300
Outpatient Medical Care (No PCP referral is necessary for OB/GYN visits, spinal manipulation, routine eye exams, or mammograms)			
Most Provider Office Visits			\$15 per visit
Routine Physical Exams (including most preventive screenings)			\$15 per visit
Well-Child Care			\$15 per visit
OB/GYN Visits			\$15 per visit
Outpatient Maternity Care (This office visit copayment will apply per visit up to 10 visits per pregnancy. After 10 visits, these services are covered in full for the remainder of your pregnancy.)			\$15 per visit
Routine Eye Exams (1 visit every 12 months)			\$15 per visit
Nutritional Counseling (When medically necessary)			\$15 per visit
Preventive Immunizations			Covered in full
Preventive Pap Smears and Mammograms			Covered in full
Non-preventive Immunizations			Covered in full
Non-routine Pap Smears and Mammograms			Covered in full
Allergy Injections			Copay may apply
Diagnostic Procedures			Covered in full
Diagnostic Imaging - General Imaging (such as X-rays and ultrasounds)			Covered in full
Diagnostic Imaging - High-Tech Imaging (MRIs, CT/CAT Scans, PET Scans, and Nuclear Cardiology)			Covered in full
Diagnostic Lab Tests			Covered in full
Speech and Short-term Physical/Occupational Therapy			\$15 per visit
Spinal Manipulation (12 visits per plan year)			\$15 per visit
Day Surgery			Covered in full
Inpatient Hospital Care (Semi-private room, unless private room is medically necessary)			
All Hospital Services (Acute Care) and Maternity Care			\$250 per admission
Skilled Nursing in Skilled Nursing Facility (up to 100 days per plan year)			Covered in full
Emergency Care			
In Doctor's Office			\$15 per visit
In Emergency Room			\$50 per visit
Mental Health*			
Outpatient Care (up to 30 visits per plan year)			\$15 per visit
Inpatient Care (Services provided at a designated facility for up to 60 days per plan year)			\$150 per admission
Substance Abuse**			
Outpatient Care (Alcohol and drug treatment, detoxification) (Up to \$500 per plan year for treatment)			\$15 per visit
Inpatient Care (Services provided at a designated facility for up to 30 days per plan year)			Error! Not a valid link. per admission
Other Health Services			
Durable Medical Equipment			Covered in full
Ambulance Service			Covered in full
Hospice Care			Covered in full
Home Health Care			Covered in full
Pediatric Dental: X-Rays (full mouth) once every 5 years. Bitewings, once every 6 months			Covered for

## ATTACHMENT - E

and periapicals as needed. Periodic oral exam, oral prophylaxis and fluoride treatment once every 6 months. children under 12

### Great Savings While You Get Healthy

In addition to your covered benefits, we offer great savings on a wide variety of healthy products, services, and treatments—from acupuncture and massage therapy to wellness programs. You save while you're taking care of your health. That's a real win-win! To learn more, visit [www.tuftshealthplan.com](http://www.tuftshealthplan.com) and click on Discounts on the Members tab.

Regular exercise is an important part of living a healthy lifestyle, and we want to do whatever we can to help you and your family incorporate activity into your daily lives. That's why **your Tufts Health Plan membership includes a \$150 rebate per household toward your health and fitness club fees.** See the fitness reimbursement flyer in your member enrollment kit for more information.

\*Outpatient and inpatient mental health services are treated the same as any other medical condition when provided as required by law for the following: biologically-based mental disorders; certain mental, behavioral or emotional disorders for children under age 19; and rape-related mental or emotional disorders. See your Tufts Health Plan member benefit document for more information.

\*\*Outpatient and inpatient substance abuse services are treated the same as mental health conditions when provided in conjunction with treatment of a mental disorder. Treatment for detoxification is not subject to substance abuse day and dollar limits listed in this document. See your Tufts Health Plan member benefit document for more information.

**There are some services that the plan does not cover.** These include, but are not limited to: A service or supply not described as a covered service in your Tufts Health Plan member benefit document • Exams required by a third party, such as your employer, an insurance company, school, or court • Cosmetic surgery or any other cosmetic procedure, except certain reconstructive procedures described in your Tufts Health Plan member benefit document • Experimental or investigational drugs, services, and procedures • Eyeglasses or contact lenses, except as described in your Tufts Health Plan member benefit document • Blood, blood donor fees, blood storage fees, blood substitutes, blood banking, cord blood banking, or blood products, except as described in your Tufts Health Plan member benefit document • Drugs for use outside of hospital, except as covered under Prescription Drug Coverage • Personal comfort items • Custodial care • A service furnished to someone other than the member • Routine foot care, except as described in your Tufts Health Plan member benefit document • Charges incurred for stays in a covered facility beyond the discharge hour • Care for conditions that state or local law requires to be treated in a public facility • Medical or surgical procedures for sexual reassignment and reversal of voluntary sterilization • Foot orthotics, except therapeutic/molded shoes for an individual with severe diabetic foot disease • Assisted reproductive technology (e.g. IVF) procedures for non-Massachusetts residents • Spinal manipulation services for members age 12 and under • Except for Emergency care, a service, supply or medication that is obtained outside of the 50 United States • Private duty nursing (block or non-intermittent nursing) • Hearing aids.

This is a summary only. Please refer to the member benefit document for a detailed explanation of your coverage. If there is a difference between the information in this benefit summary and your member benefit document, the terms of your member benefit document will govern. If you have additional questions, please call a member services specialist at 1-800-462-0224.

Offered by Total Health Plan, Inc., a Tufts Health Plan company.

**Massachusetts Requirement to Purchase Health Insurance:** As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector Web site ([www.mahealthconnector.org](http://www.mahealthconnector.org)). This health plan meets Minimum Creditable Coverage standards that are effective January 1, 2009 as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you will satisfy the statutory requirement that you have health insurance meeting these standards. This disclosure is for minimum creditable coverage standards that are effective January 1, 2009. Because these standards may change, review your health plan material each year to determine whether your plan meets the latest standards. If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its Web site at [www.mass.gov/doi](http://www.mass.gov/doi).

## ADVANTAGE EPO SUMMARY OF BENEFITS

With Tufts Health Plan Advantage EPO, health care services may be covered subject to the plan's deductible, covered with a copayment, or covered in full. The deductible is the amount you must first pay out of pocket before many services are covered. The deductible is calculated each Plan year. Once you meet the deductible, the plan covers in full services that are subject to the deductible for the remainder of the Plan year.

In addition, Advantage EPO is compatible with health reimbursement arrangements (HRAs), which are designed specifically to help with an individual's health care expenses.

### **As an Advantage EPO member:**

- You must choose a primary care provider (PCP) from the Tufts Health Plan network of providers.
- In most cases, your network PCP must provide or authorize (provide a referral for) your care.
- You do not need a referral for emergency care.

### **How services are covered with Advantage EPO**

In general, the Advantage EPO plan covers preventive and medically necessary health care services and supplies when they are provided or authorized by your network PCP. Services may be:

- **Covered subject to the plan's deductible:** Certain covered services—usually those used to diagnose, treat, or monitor health conditions (for example, an MRI)—are subject to the plan's deductible. Note: Services subject to the plan's deductible may also be performed during or in conjunction with preventive services (for example, during an office visit). The individual and family deductibles for this plan are listed below.

- **Covered in full or with a copayment:** You pay the applicable copayment at the time you receive covered health care services. With this plan, preventive services are covered in full and are not subject to the deductible. Generally, preventive services are the services your provider provides to help you stay healthy. Preventive services are needed at all ages. They might be office visits for routine physicals for children and adults, tests (also called screenings) to evaluate your general health or the health of certain parts of your body, measurements, immunizations (or shots) for children and adults, certain advice about health, or special tests at certain times in your life.

**Out-of-pocket Maximum:** Your deductible and copayments accumulate toward your out-of-pocket maximum. Once you reach your out-of-pocket maximum, you are covered in full for services subject to deductible and copayments. Pharmacy copayments are excluded from the out-of-pocket maximum. Please note that this is a summary of benefits only. For more detailed benefit information, please refer to this plan's member benefit document.

This health plan meets Minimum Creditable Coverage standards and will satisfy the individual mandate that you have health insurance.

**Prescription Drug Coverage For up to a 30-day supply at a participating retail pharmacy  
For up to a 90-day supply  
through our mail order service**

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Tier 1 \$15 \$30

Tier 2 \$30 \$60

Tier 3 \$50 \$100

Note: there is a 30-day supply limit when filling prescriptions at a retail pharmacy

### **Deductible and Out-of-Pocket Maximums (per Plan year) Individual Family**

Deductible \$250 \$500

Out-of-pocket Maximum (includes deductible and copayments) \$1,000 \$2,500

### **Outpatient Medical Care (No PCP referral is necessary for OB/GYN visits, spinal manipulation, routine eye exams, or mammograms)**

#### **PCP Specialist**

Routine Physical Exams (including most preventive screenings. Please note: some services performed during a routine office visit may be subject to your deductible.) Covered in full

Non-routine Office Visits (including PCP and specialist consultations) \$20 per visit \$35 per visit

Preventive Immunizations Covered in full

Non-preventive Immunizations Covered in full after deductible

Preventive Pap Smears and Mammograms Covered in full

Non-preventive Pap Smears and Mammograms Covered in full after deductible

Colonoscopy (without surgical intervention) Covered in full

Colonoscopy (with surgical intervention) Covered in full after deductible

Outpatient Maternity Care (This office visit copayment will apply per visit up to 10 visits per pregnancy. After 10 visits, these services are covered in full for the remainder of your pregnancy.)

\$20 per visit \$20 per visit

OB/GYN Visits \$20 per visit \$20 per visit

Well-Child Care Covered in full

Routine eye exams with an EyeMed Vision Care provider (1 visit every 12 months) Covered in full

Nutritional Counseling (When medically necessary) \$20 per visit \$35 per visit

Allergy Injections Covered in full after deductible

Speech Therapy (no visit limit); Short-term Physical Therapy (30 visits per Plan year); Covered in full after deductible

MA-1/11 Rev. 8/10

Short-term Occupational Therapy (30 visits per Plan year)

Spinal Manipulation (12 visits per Plan year) Covered in full after deductible

Diagnostic Procedures Covered in full after deductible

Diagnostic Imaging - General Imaging (such as X-rays and ultrasounds) Covered in full after deductible

Diagnostic Imaging - High-Tech Imaging

(MRIs, CT/CAT Scans, PET Scans, and Nuclear Cardiology) Covered in full after deductible

Diagnostic Lab Tests Covered in full after deductible

Day Surgery Covered in full after deductible

### **Inpatient Hospital Care (Semi-private room, unless private room is medically necessary)**

All Hospital Services (Acute Care) and Maternity Care Covered in full after deductible

Skilled Nursing in Skilled Nursing Facility (up to 100 days per Plan year) Covered in full after deductible

### **Emergency Care PCP Specialist**

In Provider's Office \$20 per visit \$35 per visit

In Emergency Room \$100 per visit

### **Mental Health**

Outpatient Care \$20 per visit

Inpatient Care (Services provided at a designated facility ) Covered in full after deductible

### **Substance Abuse**

Outpatient Care (Alcohol and drug treatment, detoxification) \$20 per visit

Inpatient Care (Services provided at a designated facility) Covered in full after deductible

### **Other Health Services**

Durable Medical Equipment Covered in full

Ambulance Service Covered in full after deductible

Hospice Care Covered in full after deductible

Home Health Care Covered in full after deductible

### **Great Savings While You Get Healthy**

We want to help you and your family incorporate activity into your daily lives. That's why your Tufts Health Plan

membership includes a **\$150 rebate** per subscriber household toward your fees for a qualified health and

## ATTACHMENT - E

fitness club.

**There are some services that the plan does not cover.** These include, but are not limited to: A service or supply not described as a covered service in your Tufts Health Plan member benefit document • Exams required

by a third party, such as your employer, an insurance company, school, or court • Cosmetic surgery or any other cosmetic procedure, except certain reconstructive procedures described in your Tufts Health Plan member

benefit document • Experimental or investigational drugs, services, and procedures • Eyeglasses or contact lenses, except as described in your Tufts Health Plan member benefit document • Blood, blood donor fees, blood storage fees, blood substitutes, blood banking, cord blood banking, or blood products, except as described

in your Tufts Health Plan member benefit document • Drugs for use outside of a hospital, except as described in

your Tufts Health Plan member benefit document • Personal comfort items • Custodial care • A service furnished to someone other than the member • Routine foot care, except as described in your Tufts Health Plan

member benefit document • Charges incurred for stays in a covered facility beyond the discharge hour • Care for conditions that state or local law requires to be treated in a public facility • Medical or surgical procedures for

sexual reassignment and reversal of voluntary sterilization • Foot orthotics, except therapeutic/molded shoes for

an individual with severe diabetic foot disease • Assisted reproductive technology (e.g. IVF) procedures for non-

Massachusetts residents • Spinal manipulation services for members age 12 and under • Except for Emergency

care or Urgent care while traveling, a service, supply or medication that is obtained outside of the 50 United States • Private duty nursing (block or non-intermittent nursing) • Hearing aids.

**This is a summary only. Please refer to the member benefit document for a detailed explanation of your coverage. If there is a difference between the information in this benefit summary and your member benefit document, the terms of your member benefit document will govern. If you have additional questions, please call a Member Specialist at 1-800-462-0224.**

Offered by Tufts Associated Health Maintenance Organization, Inc.

Massachusetts Requirement to Purchase Health Insurance: As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth

Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector Web site ([www.mahealthconnector.org](http://www.mahealthconnector.org)). This health plan meets Minimum Creditable Coverage standards

that are effective January 1, 2009 as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you will satisfy the statutory requirement that you have health insurance meeting these standards. This disclosure is for minimum creditable coverage standards that are effective January 1, 2009.

Because these standards may change, review your health plan material each year to determine whether your plan meets the latest standards. If you have

**questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its Web site at [www.mass.gov/doi](http://www.mass.gov/doi).**

## **ADVANTAGE PPO**

### **SUMMARY OF BENEFITS**

With Tufts Health Plan Advantage PPO, most health care services are covered subject to the plan's deductible or coinsurance, covered with a copayment, or covered in full. Services are covered at two levels of benefits: the in-network level of benefits and the out-of-network level of benefits.

#### **As an Advantage PPO member:**

- You can seek covered health care services from most licensed providers in or out of the Tufts Health Plan network.
- No referrals are needed.
- You do not have to choose a primary care provider (PCP).

#### **How services are covered with Advantage PPO**

In general, Advantage PPO covers preventive and medically necessary health care services and supplies in the following ways:

- **Coverage at the in-network level of benefits:** When you receive care from a provider in the Tufts Health Plan network, services may be covered subject to the plan's deductible or coinsurance, covered with a copayment, or covered in full.
- **Covered subject to the plan's deductible:** Certain covered services—usually those used to diagnose, treat, or monitor health conditions (for example, an MRI)—are subject to the plan's deductible. The deductible is the amount you must first pay out of pocket each plan year before many services are covered. Once you meet the deductible, those services are covered in full for the remainder of the plan year. Note: Services subject to the plan's deductible may also be performed during or in conjunction with preventive services; for example, during an office visit.
- **Covered in full or with a copayment:** You pay the applicable copayment at the time you receive covered health care services. With this plan, preventive services are covered in full and are not subject to the plan's deductible. Generally, preventive services are the services your provider provides to help you stay healthy. Preventive services are needed at all ages. They might be office visits for routine physicals for children and adults, tests (also called screenings) to evaluate your general health or the health of certain parts of your body, measurements, preventive immunizations (or shots) for children and adults, certain advice about health, or special tests at certain times in your life.
- **Covered subject to coinsurance:** Coinsurance is a percentage of the covered medical costs you are responsible for paying. You pay coinsurance on durable medical



equipment until you reach the plan's out-of-pocket maximum, after which you are covered in full.

• **Coverage at the out-of-network level of benefits:** When you receive care from a provider who is not in the Tufts Health Plan network, services will be covered subject to the plan's deductible and then coinsurance. When you receive covered out-of-network services, you pay coinsurance until you reach the plan's out-of-pocket maximum, after which you are covered in full up to the reasonable charge for covered services for the remainder of the plan year. You may also be responsible for paying any difference between what the plan covers and what an out-of-network provider charges for a service.

The individual and family deductibles and out-of-pocket maximums for this plan are listed in this benefit summary. Please note that this is a summary of benefits only. For more detailed benefit information, please refer to this plan's member benefit document.

This health plan meets Minimum Creditable Coverage standards and will satisfy the individual mandate that you have health insurance.

#### **Prescription Drug Coverage**

**For up to a 30-day supply at a participating retail pharmacy**

**For up to a 90-day supply through our mail order service**

Tier 1 \$15 \$30

Tier 2 \$30 \$60

Tier 3 \$50 \$100

**Note: there is a 30-day supply limit when filling prescriptions at a retail pharmacy**  
**Deductible and Out-of-Pocket Maximums (per plan year) Individual Family**

Deductible \$250 \$500

Out-of-pocket Maximum (includes deductible, coinsurance, and copayments) \$1,000 \$2,500

#### **In-Network**

##### **Outpatient Medical Care**

##### **PCP Specialist**

##### **Out-of-Network (after deductible)**

Routine Physical Exams (including most preventive screenings. Please note: some services performed during a routine office visit may be subject to your deductible.)

Covered in full Plan covers 80%

Non-routine Office Visits (including PCP and specialist consultations) \$20 per visit \$35 per visit Plan covers 80%

Preventive Immunizations Covered in full Plan covers 80%

Non-preventive Immunizations Covered in full after deductible Plan covers 80%

Preventive Pap Smears and Mammograms Covered in full Plan covers 80%

Non-preventive Pap Smears and Mammograms Covered in full after deductible Plan covers 80%

Colonoscopy (without surgical intervention) Covered in full Plan covers 80%

Colonoscopy (with surgical intervention) Covered in full after deductible Plan covers 80%

Outpatient Maternity Care (This office visit copayment will apply per visit up to 10 visits per pregnancy. After 10 visits, these services are covered in full for the remainder of your pregnancy.)

\$20 per visit \$20 per visit Plan covers 80%

OB/GYN Visits \$20 per visit \$20 per visit Plan covers 80%

Well-Child Care Covered in full Plan covers 80%

Routine eye exams (1 visit every 12 months)—you must use an EyeMed

Vision Care provider to be covered at the in-network level of benefits

Covered in full Plan covers 80%

Nutritional Counseling (When medically necessary) \$20 per visit \$35 per visit Plan covers 80%

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Allergy Injections Covered in full after deductible Plan covers 80%

Speech Therapy (no visit limit); Short-term Physical Therapy (30 visits per plan year); Short-term Occupational Therapy (30 visits per plan year)

Covered in full after deductible

Plan covers 80%

Spinal Manipulation (12 visits per plan year) Covered in full after deductible Plan covers 80%

Diagnostic Procedures Covered in full after deductible Plan covers 80%

Diagnostic Imaging - General Imaging

(such as X-rays and ultrasounds) Covered in full after deductible Plan covers 80%

Diagnostic Imaging - High-Tech Imaging

(MRIs, CT/CAT Scans, PET Scans, and Nuclear Cardiology) Covered in full after deductible Plan covers 80%

Diagnostic Lab Tests Covered in full after deductible Plan covers 80%

Day Surgery Covered in full after deductible Plan covers 80%

**Inpatient Hospital Care  
(after deductible)**

All Hospital Services (Acute Care) and Maternity Care Covered in full after deductible Plan covers 80%

Skilled Nursing in Skilled Nursing Facility

(up to 100 days per plan year)

Covered in full after deductible Plan covers 80%

**Emergency Care PCP Specialist**

In Provider's Office \$20 per visit \$35 per visit

In Emergency Room \$100 per visit

**Mental Health  
(deductible)**

Outpatient Care \$20 per visit Plan covers 80%

Inpatient Care Covered in full after deductible Plan covers 80%

**Substance Abuse Out-of-Network  
(after deductible)**

Outpatient Care (Alcohol and drug treatment, detoxification) \$20 per visit Plan covers 80%

Inpatient Care Covered in full after deductible Plan covers 80%

**Other Health Services Out-of-Network  
(after deductible)**

Durable Medical Equipment Covered in full Plan covers 80%

Ambulance Service Covered in full after deductible Plan covers 80%

Hospice Care Covered in full after deductible Plan covers 80%

Home Health Care Covered in full after deductible Plan covers 80%

We want to help you and your family incorporate activity into your daily lives. That's why your Tufts Health Plan membership

includes a **\$150 rebate** per subscriber household toward your fees for a qualified health and fitness club.

**There are some services that the plan does not cover.** These include, but are not limited to: A service or supply not

described as a covered service in your Tufts Health Plan member benefit document • Exams required by a third party, such

as your employer, an insurance company, school, or court • Cosmetic surgery or any other cosmetic procedure, except

certain reconstructive procedures described in your Tufts Health Plan member benefit document • Experimental or investigational drugs, services, and procedures • Eyeglasses or contact lenses, except as described in your Tufts Health Plan

member benefit document • Blood, blood donor fees, blood storage fees, blood substitutes, blood banking, cord blood

banking, or blood products, except as described in your Tufts Health Plan member benefit document • Drugs for use outside

of a hospital, except as described in your Tufts Health Plan member benefit document • Personal comfort items • Custodial

care • A service furnished to someone other than the member • Routine foot care, except as described in your Tufts Health

Plan member benefit document • Charges incurred for stays in a covered facility beyond the discharge hour • Care for

conditions that state or local law requires to be treated in a public facility • Medical or surgical procedures for sexual

reassignment and reversal of voluntary sterilization • Foot orthotics, except therapeutic/molded shoes for an individual with

severe diabetic foot disease • Assisted reproductive technology (e.g. IVF) procedures for non-Massachusetts residents •

Spinal manipulation services for members age 12 and under • Except for Emergency care or urgent care while traveling, a

service, supply or medication that is obtained outside of the 50 United States • Private duty nursing (block or nonintermittent

nursing) • Hearing aids.

**This is a summary only. Please refer to your plan's member benefit document for more detailed information. If**

**there is a difference between the information in this benefit summary and your member benefit document,**



**member benefit document is legally binding. If you have additional questions, please call a Member Specialist at 1-800-462-0224.**

Offered by Tufts Insurance Company or Tufts Benefit Administrators, Inc., both Tufts Health Plan companies. Massachusetts Requirement to Purchase Health Insurance: As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector Web site ([www.mahealthconnector.org](http://www.mahealthconnector.org)). This health plan meets Minimum Creditable Coverage standards that are effective January 1, 2009 as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you will satisfy the statutory requirement that you have health insurance meeting these standards. This disclosure is for minimum creditable coverage standards that are effective January 1, 2009. Because these standards may change, review your health plan material each year to determine whether your plan meets the latest standards. If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its Web site at [www.mass.gov/doi](http://www.mass.gov/doi).

The Harvard Pilgrim Tiered Copayment HMO 1

# Schedule of Benefits

## The Harvard Pilgrim Tiered Copayment HMO

*Services listed are covered when Medically Necessary and provided or arranged by Harvard Pilgrim Health Care providers. Please see your Benefit Handbook for details.*

### Member Cost Sharing Summary

Your benefits are being provided on a Plan Year basis. Your Plan Year begins on your Employer's Anniversary Date. Please see your Benefit Handbook for more details. If you do not know your Employer's Anniversary Date, please contact your Employer's benefits office or call the Member Services Department at 1-888-333-4742.

#### **Deductible**

A Deductible is a specific annual dollar amount that is payable by the Member before medical benefits subject to the Deductible are available under the Plan. Not all services under this Plan are subject to the Deductible. For services subject to the Deductible, you must satisfy your Deductible before Harvard Pilgrim provides coverage for these benefits. Deductible amounts are incurred as of the date of service.

Your Plan has a \$250 per Member Deductible and a \$500 per family Deductible per Plan Year.

Unless a family Deductible applies, each Member is responsible for the per Member Deductible for covered services each Plan Year. If a family Deductible applies, it is met when any combination of Members in a covered family incur expenses for services subject to the Deductible that total the annual family Deductible.

Your Deductible applies to all services covered under the Plan except the following:

- ☐ Examinations and consultations performed by physicians and podiatrists
- ☐ The Preventive Services as listed in the "Physician Services" Section of this Schedule of Benefits
- ☐ Prenatal and postpartum care in a physician's office
- ☐ Routine nursery charges for newborn care
- ☐ Outpatient mental health care services
- ☐ Pediatric preventive dental care
- ☐ Blood glucose monitors, insulin pumps and infusion devices
- ☐ Early intervention services

Please note that (1) treatments and procedures by physicians and podiatrists and (2) psychological testing and neuropsychological assessments are subject to the Deductible.

#### **Deductible and Other Cost Sharing**

For certain services, both a Deductible and Copayment may apply. In such cases, you must completely satisfy the Deductible before the Plan pays benefits on services subject to the Deductible. Once you have satisfied the annual Deductible, you are still responsible for any applicable Copayments.

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The Harvard Pilgrim Tiered Copayment HMO 2

### **Copayments**

A Copayment applies to all services except where specifically noted in the table below.

A Copayment is a dollar amount that is payable by the Member for certain covered services. The Copayment is due at the time services are rendered or when billed by the provider.

There are two types of office visit Copayments that apply to your Plan. A lower Copayment, known as “Copayment Level 1,” applies to some outpatient services, including most primary care, obstetrical care, gynecological care, mental health care and substance abuse rehabilitation. Most outpatient specialty care requires payment of a higher Copayment, known as “Copayment Level 2.” The Level 1 and Level 2 Copayments that apply to your Plan are listed below.

**Copayment Level 1:** Your Plan has a \$20 Copayment per visit.

**Copayment Level 2:** Your Plan has a \$35 Copayment per visit.

#### **Copayment Level 1**

Special Level 1 Services: Copayment Level 1 applies to the following outpatient services:

- ☐ Voluntary termination of pregnancy
- ☐ Voluntary sterilization
- ☐ Mental health care (including the treatment of substance abuse disorders)
- ☐ Physical therapy
- ☐ Occupational therapy
- ☐ Speech therapy
- ☐ Routine eye examinations
- ☐ Artificial insemination
- ☐ Advanced reproductive technologies

In addition to the Special Level 1 list, Copayment Level 1 applies to covered outpatient professional services, other than services received at a professional office operated by a hospital, from the following types of providers:

- ☐ All Primary Care Physicians. The term “Primary Care Physician” (PCP) includes the following specialties: Internal Medicine, Family Practitioner, General Practitioner and Pediatrician
- ☐ Obstetricians and Gynecologists
- ☐ Certified Nurse Midwives
- ☐ Nurse Practitioners who bill independently

#### **Copayment Level 2**

Copayment Level 2 applies to the following outpatient professional services:

- ☐ Any covered services or provider not listed under Copayment Level 1
- ☐ Any service provided in a hospital operated doctor’s office, except the Special Level 1 Services listed above.

If a provider is categorized as both a Copayment Level 1 provider and a Copayment Level 2 provider, Copayment Level 1 applies. For example, if a provider is both a PCP and a cardiologist, you will be responsible for Copayment Level 1.

Your identification card indicates the Copayment amounts for the Plan’s most frequently used services. This *Schedule of Benefits* provides further detail on all Copayment requirements.

The Harvard Pilgrim Tiered Copayment HMO 3

*Please note:* In very limited cases the Copayment may exceed the contract rate payable by the Plan for a service. If the Copayment is greater than the contract rate, you are responsible for the full Copayment, and the provider keeps the entire Copayment.

### **Out-of-Pocket Maximums**

Your plan has an Out-of-Pocket Maximum of \$1,000 per Member and \$2,500 per covered family per Plan Year. This is the total amount in Copayments and Deductible you (or your covered family) are required to pay each Plan Year for services covered by the Plan, not including riders providing benefits for prescription drugs or vision hardware. The Plan will notify you when you have reached your Out-of-Pocket Maximum. If you feel you have reached the Out-of-Pocket Maximum but have not been notified, please contact the Plan.

The Deductible applies to all services except where specifically noted below.

The Harvard Pilgrim Tiered Copayment HMO 4

## **Service**

### **Inpatient Acute Hospital Services**

All covered services, including the following:

- Coronary care

Covered in full after the  
Deductible has been met.

- Hospital services
- Intensive care
- Semi-private room and board
- Physicians' and surgeons' services including consultations

**Day Surgery** Covered in full after the  
Deductible has been met.

### **Hospital Outpatient Department Services**

- All covered services, except emergency room care Covered in full after the  
Deductible has been met.

No cost sharing applies to certain preventive care services and tests. See "Physician Services" and "Preventive Services" section below.

### **Diagnostic Procedures (including all technical and professional charges)**

All covered services, including the following:

- Laboratory tests, Nuclear Magnetic Resonance Imaging, Ultrasounds\* and x-rays  
(except for the x-rays provided as part of a pediatric preventive dental visit)

Covered in full after the  
Deductible has been met.

- Endoscopic procedures
- Blood and urine tests\*
- Diagnostic procedures\*

\*No cost sharing applies to fetal ultrasounds and any services and tests listed in the  
"Preventive Services" section below.

### **Emergency Services**

- You are always covered for care in a Medical Emergency. A referral from your  
PCP is not needed. In a Medical Emergency, you should go to the nearest  
emergency facility or call 911 or other local emergency number. If you are  
hospitalized, you must call your PCP within 48 hours or as soon as you can.

Please note that this requirement is met if your attending physician has already  
given notice to your PCP.

\$100 Copayment per visit.

This Copayment is waived  
if admitted directly to the  
hospital from the

emergency room. See  
"Physician Services" for  
coverage of emergency  
services by a physician in  
any other location.

The Harvard Pilgrim Tiered Copayment HMO 5

### **Physician Services (including covered services by podiatrists)**

#### **Examinations and Consultations**

- Examinations for illness or injuries

Copayment Level 1: \$20

Copayment per visit. The  
Deductible does not apply to  
these services.

Copayment Level 2: \$35

Copayment per visit. The  
Deductible does not apply to  
these services.

- Routine eye examinations, including glaucoma screenings
- Routine hearing examinations and tests
- Health education, including nutritional counseling and diabetes education and training
- Family planning consultations
- Medication management, including psychopharmacological services
- Consultation with specialists
- Consultations concerning contraception and hormone replacement therapy
- Preventive care, including routine physical, gynecological, well child, school, camp, sports and premarital examinations

Covered in full. The

Deductible does not apply to these services.

### **Treatments and Procedures (including all diagnostic procedures)**

All covered services including the following:

- Administration of injections

Covered in full after the

Deductible has been met.

- Allergy treatments
- Diagnostic procedures
- Casting, suturing and the application of dressings
- Chemotherapy
- Radiation therapy
- Infertility treatment and procedures
- Pregnancy testing
- Voluntary sterilization, including tubal ligation
- Voluntary termination of pregnancy
- Insertion, removal and fitting of birth control devices
- Genetic counseling
- Surgical procedures
- Non-routine foot care
- Foot care for members with severe diabetic foot disease
- Administration of allergy injections
- Medical treatment of temporomandibular joint dysfunction (TMD)

The Harvard Pilgrim Tiered Copayment HMO 6

### **Preventive Services (including all technical and professional charges)**

The following preventive services and tests as defined by federal law:

- Abdominal aortic aneurysm screening (for males 65-75 one time only, if ever smoked)

Covered in

full. The

Deductible

does not apply

to these

services.

- Alcohol misuse screening and counseling (primary care visits only)
- Aspirin for the prevention of heart disease (primary care counseling only)
- Autism screening (for children at 18 and 24 months of age, primary care visits only)
- Behavioral assessments (children of all ages; developmental surveillance, in primary care settings)
- Blood pressure screening (adults, without known hypertension)
- Breast cancer chemoprevention (counseling only for women at high risk for breast cancer and low risk for adverse effects of chemoprevention)
- Breast cancer screening, including mammograms and counseling for genetic susceptibility screening
- Cervical cancer screening, including pap smears

- ☐ Cholesterol screening (for adults only)
- ☐ Colorectal cancer screening, including colonoscopy, sigmoidoscopy and fecal occult blood test
- ☐ Dental caries prevention - oral fluoride (for children to age 5 only) (Note: Coverage for fluoride is only provided if your Plan includes outpatient pharmacy coverage.)
- ☐ Depression screening (adults, children ages 12-18, primary care visits only)
- ☐ Diabetes screenings
- ☐ Diet behavioral counseling (included as part of annual visit and intensive counseling by primary care clinicians or by nutritionists and dieticians)
- ☐ Dyslipidemia screening (for children at high risk for higher lipid levels)
- ☐ Folic acid supplements (women planning or capable of pregnancy only) (Note: coverage for folic acid is only provided if your Plan includes outpatient pharmacy coverage.)
- ☐ Hemoglobin A1c
- ☐ Hepatitis B testing
- ☐ HIV screening
- ☐ Immunizations, including flu shots (for children and adults as appropriate)
- ☐ Iron deficiency prevention (primary care counseling for children age 6 to 12 months only)
- ☐ Lead screening (children at risk)
- ☐ Microalbuminuria test
- ☐ Obesity screening (adults and children screening only, in primary care settings)
- ☐ Osteoporosis screening (screening to begin at age 60 for women at increased risk)
- ☐ Ovarian cancer susceptibility screening
- ☐ Sexually transmitted diseases (STDs) – screenings and counseling
- ☐ Tobacco use counseling (primary care visits only)
- ☐ Total cholesterol tests
- ☐ Tuberculosis skin testing
- ☐ Vision screening (children to age 5 only)

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### **Preventive Services (including all technical and professional charges) (Continued)**

Under federal law the list of preventive care services covered under this benefit may change periodically based on the recommendations of the following agencies:

- a. Grade “A” and “B” recommendations of the United States Preventive Services Task Force;
- b. With respect to immunizations, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and
- c. With respect to services for woman, infants, children and adolescents, the Health Resources and Services Administration.

Information on the recommendations of these agencies may be found on the web site of the US Department of Health and Human Services at:

<http://www.healthcare.gov/center/regulations/prevention/recommendations.html>

Harvard Pilgrim will add or delete services from this benefit for preventive care in accordance with changes in the recommendations of the agencies listed above. You can find a list of the current recommendations for preventive care on Harvard Pilgrim’s web site at [www.harvardpilgrim.org](http://www.harvardpilgrim.org).

Coverage is also provided for the following preventive services and tests:

- ☐ Hepatitis C testing

Covered in full. The

Deductible does not apply to these services.

- ☐ Prostate-specific antigen (PSA) screening
- ☐ Fetal ultrasounds
- ☐ Routine hemoglobin
- ☐ Routine urinalysis
- ☐ Alpha-Fetoprotein (AFP) and Group B streptococcus (GBS) test
- ☐ All lab handling and venipuncture charges

### **Maternity Services**

- ☐ Prenatal and postpartum care, including counseling about alcohol and tobacco use, services to promote breastfeeding, routine urinalysis and screenings for the

following: asymptomatic bacteriuria; hepatitis B infection; HIV and screenings for STDs (chlamydia, gonorrhea and syphilis); iron deficiency anemia; and Rh (D) incompatibility.

Covered in full.

□ All hospital services for mother, including inpatient physician services Covered in full after the Deductible has been met.

□ Routine nursery charges for newborn care, including prophylactic medication to prevent gonorrhea and screenings for the following: hearing loss; congenital hypothyroidism; phenylketonuria (PKU); and sickle cell disease.

Covered in full.

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## **Mental Health Care (Including the Treatment of Substance Abuse Disorders)**

### **Inpatient Services**

□ Mental health care services Covered in full after the Deductible has been met.

### **Intermediate Care Services**

□ Acute residential treatment (including detoxification), crisis stabilization and inhome family stabilization Covered in full after the Deductible has been met.

□ Intensive outpatient programs, partial hospitalization and day treatment programs

### **Outpatient Services**

□ Mental health care services

Group therapy \$10 Copayment per visit.

Individual therapy \$20 Copayment per visit. The

Deductible does not apply to these services.

□ Detoxification \$20 Copayment per visit. The Deductible does not apply to these services.

□ Medication management \$20 Copayment per visit. The Deductible does not apply to these services.

□ Psychological testing and neuropsychological assessment Covered in full after the Deductible has been met.

### **Home Health Care Services**

□ Home care services Covered in full after the

□ Intermittent skilled nursing care Deductible has been met.

No cost sharing or benefit limit applies to durable medical equipment, physical therapy or occupational therapy received as part of authorized home health care.

### **Dental Services**

□ Preventive care for children through age 12. Two visits per Member per Plan Year, including examination, cleaning, x-rays and fluoride treatment.

\$20 Copayment per visit. The

Deductible does not apply to these services.

□ Extraction of unerupted teeth impacted in bone Covered in full after the Deductible has been met.

□ Initial emergency treatment (within 72 hours of injury) Covered in full after the Deductible has been met. For

emergency room care, see your "Emergency Services"

Copayment below. For care in any other location, covered in full after the Deductible has been met.



The Harvard Pilgrim Tiered Copayment HMO 9

### **Skilled Nursing Facility Care Services**

□ Covered up to 100 days per Plan Year Covered in full after the Deductible has been met.

### **Inpatient Rehabilitation Services**

□ Covered up to 100 days per Plan Year Covered in full after the Deductible has been met.

### **Diabetes Equipment and Supplies**

□ Therapeutic molded shoes and inserts, dosage gauges, injectors, lancet devices, voice synthesizers and visual magnifying aids

Covered in full after the

Deductible has been met.

□ Blood glucose monitors, insulin pumps and supplies and infusion devices Covered in full. The Deductible does not apply to these services.

□ Insulin, insulin syringes, insulin pens with insulin, lancets, oral agents for controlling blood sugar, blood test strips, and glucose, ketone and urine test strips

Subject to the applicable

prescription drug Copayment

listed on your ID card.

### **Durable Medical Equipment including Prosthetics**

Coverage includes, but is not limited to:

□ Durable medical equipment

Covered in full after the

Deductible has been met.

□ Prosthetic devices (including artificial arms and legs)

□ Ostomy supplies

□ Breast prostheses, including replacements and mastectomy bras

□ Oxygen and respiratory equipment

□ Wigs - up to a limit of \$350 per Plan Year when needed as a result of any form of cancer or leukemia, alopecia areata, alopecia totalis or permanent hair loss due to injury

### **Hypodermic Syringes and Needles**

□ Hypodermic syringes and needles to the extent Medically Necessary, as required by Massachusetts law

Subject to the applicable

prescription drug Copayment

listed on your ID card.

The Harvard Pilgrim Tiered Copayment HMO 10

### **Other Health Services**

□ Cardiac rehabilitation

Covered in full after the

Deductible has been met.

□ Dialysis

□ Physical and occupational therapies - up to 90 consecutive days per condition per Plan Year

□ Speech-language and hearing services, including therapy

□ Hospice services

□ Ambulance services

□ Low protein foods (\$5,000 per Member per Plan Year)

□ State mandated formulas

□ House calls

□ Early intervention services up to a maximum of \$5,200 per Member per Plan

Year and a lifetime maximum of \$15,600 Covered in full.

□ Vision hardware for special conditions Covered in full after the Deductible has been met., up to the applicable benefit limits as described in the Benefit Handbook.

The Harvard Pilgrim Tiered Copayment HMO 11

## Special Enrollment Rights

For Subscribers enrolled through an Employer Group:

If an employee declines enrollment for the employee and his or her Dependents (including his or her spouse) because of other health insurance coverage, the employee may be able to enroll himself or herself, along with his or her Dependents in this Plan if the employee or his or her Dependents lose eligibility for that other coverage (or if the employer stops contributing toward the employee's or Dependents' other coverage). However, enrollment must be requested within 30 days after other coverage ends (or after the employer stops contributing toward the employee's or Dependents' other coverage). In addition, if an employee has a new Dependent as a result of marriage, birth, adoption or placement for adoption, the employee may be able to enroll himself or herself and his or her Dependents. However, enrollment must be requested within 30 days after the marriage, birth, adoption or placement for adoption.

Special enrollment rights may also apply to persons who lose coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for state premium assistance under Medicaid or CHIP. An employee or Dependent who loses coverage under Medicaid or CHIP as a result of the loss of Medicaid or CHIP eligibility may be able to enroll in this Plan, if enrollment is requested within 60 days after Medicaid or CHIP coverage ends. An employee or Dependent who becomes eligible for group health plan premium assistance under Medicaid or CHIP may be able to enroll in this Plan if enrollment is requested within 60 days after the employee or Dependent is determined to be eligible for such premium assistance.

## Membership Requirements

There are a few important requirements that you must meet in order to be covered by the Plan. (Please see your *Benefit Handbook* for a complete description).

- Members must live in the HPHC's Enrollment area for at least nine months of the year. An exception is made for full-time student dependents and dependents enrolled under a Qualified Medical Child Support Order.
- All your medical and health care needs must be provided or arranged by your Primary Care Physician (PCP), except in a Medical Emergency, when you are temporarily outside the HPHC Service Area or when you need one of the special services, which do not require a referral. The HPHC Service Area is the state in which you live.

## Exclusions

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- Services not approved, arranged or provided by your PCP except: (1) in a Medical Emergency; (2) when you are outside of the Service Area; or (3) the special services that do not require a referral listed in your Benefit Handbook
- Cosmetic procedures, except as described in your Benefit Handbook
- Commercial diet plans or weight loss programs and any services in connection with such plans or programs
- Transsexual surgery, including related drugs or procedures
- Drugs, devices, treatments or procedures which are Experimental or Unproven
- Refractive eye surgery, including laser surgery and orthokeratology, for correction of myopia, hyperopia and astigmatism



- Transportation other than by ambulance
- Costs for any services for which you are entitled to treatment at government expense, including military service connected disabilities
- Costs for services covered by workers' compensation, third party liability, other insurance coverage or an employer under state or federal law
- Hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy
- Routine foot care, biofeedback, pain management programs, massage therapy, including myotherapy, and sports medicine clinics
- Any treatment with crystals
- Blood and blood products
- Educational services (including problems of school performance) or testing for developmental, educational or behavioral problems except services covered under Early Intervention
- Mental health care (including the treatment of substance abuse disorders) that are (1) provided to Members who are confined or committed to a jail, house of correction, prison or custodial facility of the Department of Youth Services or (2) provided by the Department of Mental Health
- Sensory integrative praxis tests
- Physical examinations for insurance, licensing or employment
- Vocational rehabilitation or vocational evaluations on job adaptability, job placement or therapy to restore function for a specific occupation
- Rest or custodial care
- Personal comfort or convenience items (including telephone and television charges), exercise equipment, wigs (except as required by state law and specifically covered in this Schedule of Benefits), derotation knee braces and repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage or theft
- Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services
- Reversal of voluntary sterilization (including procedures necessary for conception as a result of voluntary sterilization)
- Any form of surrogacy
- Infertility treatment for Members who are not medically infertile
- Routine maternity (prenatal and postpartum) care when you are traveling outside the Service Area
- Delivery outside the Service Area after the 37th

week of pregnancy or after you have been told that you are at risk for early delivery

- ☐ Planned home births
- ☐ Devices or special equipment needed for sports or occupational purposes
- ☐ Care outside the scope of standard chiropractic practice, including, but not limited to, surgery, prescription or dispensing of drugs or medications, internal examinations, obstetrical practice or treatment of infections and diagnostic testing for chiropractic care other than an initial x-ray
- ☐ Services for which no charge would be made in the absence of insurance
- ☐ Charges for any products or services, including, but not limited to, professional fees, medical equipment, drugs and hospital or other facility charges that are related to any care that is not a covered service under this Handbook
- ☐ Services for non-Members
- ☐ Services after termination of membership
- ☐ Services or supplies given to you by: (1) anyone related to you by blood, marriage or adoption or (2) anyone who ordinarily lives with you

## Exclusions

The Harvard Pilgrim Tiered Copayment HMO 13

- ☐ Charges for missed appointments
- ☐ Services that are not Medically Necessary
- ☐ Services for which no coverage is provided in the *Benefit Handbook*, *Schedule of Benefits* or *Prescription Drug Brochure* (if your Plan includes prescription drug coverage)
- ☐ Any home adaptations, including, but not limited to, home improvements and home adaptation equipment
- ☐ All charges over the semi-private room rate, except when a private room is Medically Necessary
- ☐ Hospital charges after the date of discharge
- ☐ Follow-up care to an emergency room visit unless provided or arranged by your PCP
- ☐ Services for a newborn who has not been enrolled as a Member, other than nursery charges for routine services provided to a healthy newborn
- ☐ If your Plan does not include coverage for outpatient prescription drugs, there is no coverage for birth control drugs, implants, injections and devices
- ☐ Acupuncture, aromatherapy and alternative medicine
- ☐ Dentures
- ☐ Dental services, except the specific dental services listed in your *Benefit Handbook* and this *Schedule of Benefits*. Restorative, periodontal,

orthodontic, endodontic, prosthodontic and dental services for temporomandibular joint dysfunction (TMD) are not covered. Removal of impacted teeth to prepare for or support orthodontic, prosthodontic or periodontal procedures and dental fillings, crowns, gum care, including gum surgery, braces, root canals, bridges and bonding.

☐ Eyeglasses, contact lenses and fittings, except as listed in your *Benefit Handbook* and this *Schedule of Benefits*

☐ Hearing aids

☐ Foot orthotics, except for the treatment of severe diabetic foot disease

☐ Methadone maintenance

☐ Private duty nursing

☐ If a service is listed as requiring that it be provided at a Center of Excellence, no coverage will be provided under your *Benefit Handbook* and this *Schedule of Benefits* if that service is received from a provider that has not been designated as a Center of Excellence by HPHC.

☐ Health resorts, recreational programs, camps, wilderness programs, outdoor skills programs, relaxation or lifestyle programs, including any services provided in conjunction with, or as part of such types of programs.

☐ Services for any condition with only a “V Code” designation in the Diagnostic and Statistical Manual of Mental Disorders, which means that the condition is not attributable to a mental disorder.

☐ Chiropractic services, including osteopathic

manipulation.

## Attachment F- Page 1

### Price Proposal

Proposer: \_\_\_\_\_

Addendum No. \_\_\_\_\_

Tufts EPO, POS and Harvard Pilgrim EPO  
For City of Newton  
Specific Stop-Loss:  
7/01/2014 to 6/30/2015

DEDUCTIBLE	CONTRACT TYPE	ENROLLMENT	MONTHLY RATE	EST ANNUAL COST
\$250,000	Individual	1482		
	Family	1562		
	Total	3044		
\$275,000	Individual	1482		
	Family	1562		
	Total	3044		
\$300,000	Individual	1482		
	Family	1562		
	Total	3044		

The undersigned certifies under the penalties of perjury that this bid has been made and submitted in good faith and without collusion or fraud with any other person. As used in this section the word "person" shall mean any natural person, business, partnership, corporation, union, committee, club or other organization, entity, or group of individuals. The undersigned further certifies under penalty of perjury that the said undersigned is not presently debarred from public contracting or subcontracting under any applicable debarment provisions of any chapter of the General Laws or any rule or regulation promulgated thereunder.

Date \_\_\_\_\_

\_\_\_\_\_  
(Name of General Bidder)

BY: \_\_\_\_\_

\_\_\_\_\_  
(Printed Name and Title of Signatory)

\_\_\_\_\_  
(Business Address)

\_\_\_\_\_  
(City, State Zip)

\_\_\_\_\_  
(Telephone)

\_\_\_\_\_  
(FAX)

\_\_\_\_\_  
(E-mail Address)

**NOTE:** If the bidder is a corporation, indicate state of incorporation under signature, and affix corporate seal; if a partnership, give full names and residential addresses of all partners; if an individual, give residential address if different from business address; and, if operating as a d/b/a give full legal identity. Attach additional pages as necessary.

## **ATTACHMENT G**

### **Contractual Requirements**

The reinsurance contract awarded and signed by the City of Newton will comply with all of the following requirements:

1. Reinsurance will apply to the plans named in this Request for Quotations, which are currently administered by Tufts Total Health Plan and Harvard Pilgrim Health Care.
2. For the above named health plans, reinsurer will reimburse City of Newton for claims exceeding the specific deductible per claimant based on the policy terms selected by the City of Newton.
3. Reinsurer will cover subscriber plus dependents including covered retirees and COBRA beneficiaries.
4. Reinsurer will cover all benefits of City of Newton's health plans, including but not limited to medical, prescription drugs, mental and nervous treatment, substance abuse treatment and current and future government mandated benefits. (*Note 1: City of Newton plans are not ERISA plans, and City of Newton adopts state and federal government mandated benefits.*)
5. Reinsurer will cover mental health/nervous claims at the same level as medical/surgical claims.
6. Reinsurer will reimburse City of Newton based on the contractual basis of payment applied by the claims administrator/health plan even if basis of payment exceeds charges. Reinsurer will not pay the lesser of charges or actual contractual basis of payment.
7. Reinsurer will not exclude from coverage covered employees, dependents of employees, retirees, and dependents of retirees with pre-existing conditions.
8. Reinsurer will not exclude from coverage covered members who are not actively at work at the time the policy goes into effect or during the term of the policy.
9. Reinsurer will not exclude from coverage dependents who are hospitalized or otherwise institutionalized at the time the reinsurance policy goes into effect.
10. Reinsurer will not exclude from coverage "Late Entrants" into the City of Newton health plans, such as new hires and those who have lost other coverage as through a spouse.
11. Massachusetts municipal employees hired prior to April 1986 did not pay into Medicare, and, therefore, many not have Medicare eligibility. Therefore, the reinsurer selected by the City of Newton agrees to reimburse for excess claims for retirees who are 65 and older and not eligible for Medicare.
12. Reinsurer will cover all City of Newton plan members at the selected specific deductible and with a either a maximum benefit payable of not less than \$2 million benefit, depending upon the option selected by the City of Newton. No special underwriting for high cost claimants, i.e. no "lasering" will be permitted.
13. Reinsurer will designate surcharges imposed by the Mass. Uncompensated Care law of 1997 paid on hospital charges and outpatient facility charges including day surgery centers as eligible claims expenses for the City of Newton.
14. Reinsurer will designate surcharges paid to the Pool Administrator of the State of New York under the New York Health Care Reform Act of 1996 as eligible claims expense for the City of Newton.
15. Reinsurer will reimburse for claims that exceed the specific deductible according to the policy when filed late because the health plan/claims administer did not report the claim to the client in a timely manner, provided the client reports the claim to the broker or carrier within five business days of receipt of the information from the health plan.

**STATEMENT of COMPLIANCE with CONTRACTUAL REQUIREMENTS  
in ATTACHMENT G of CITY OF NEWTON REQUEST for QUOTATIONS for REINSURANCE**

The undersigned certifies that if the reinsurance carrier, \_\_\_\_\_,  
Name of Carrier

is awarded the reinsurance contract sought through this Request for Proposal process, carrier will enter into a contract with the City of Newton that complies with all of the contractual requirements specified in **Attachment G** of the City of Newton's Request for Quotations issued May, 2012 and proposals due June 1, 2012. There will be no exceptions. If the reinsurance carrier's standard contract does not meet all of the requirements specified in Attachment G, carrier will prepare, sign, and submit amendments to the contract in a timely manner to render the contract in compliance.

The undersigned also acknowledges that if reinsurance carrier does not comply with Contractual Requirements, the City of Newton will exercise its right to withdraw the contract award.

\_\_\_\_\_  
(Signature of individual authorized to bind the reinsurance carrier) (Date)

COMMONWEALTH OF MASSACHUSETTS

\_\_\_\_\_  
(County)

Then appeared before me the above-named \_\_\_\_\_

and having been duly sworn stated that the foregoing statements were true and correct.

\_\_\_\_\_  
(Notary Public)

My commission expires:

\_\_\_\_\_  
(Date)

Federal Identification Number:\_\_\_\_\_

## **ATTACHMENT - H**

### **Rate History and Miscellaneous Information**

Since July 1, 1994, the City of Newton has had the same plans for its employees and its retirees.

The two Tufts plans have been self-insured since July 1, 1994. They are:

Tufts EPO plan  
Tufts POS/OOA/ Plan

The Tufts PPO Plan and EPO Advantage plans were added 8/1/11.

Harvard Pilgrim Advantage plan was added 8/1/11.

The Harvard Pilgrim HMO has also been in place since July 1, 1994. On July 1, 2000 the City chose to self-insure this plan.

The monthly rates for these plans for the last three years are as follows:

July 1, 2011:	Individual	Family
Tufts EPO	628.87	1702.01
Tufts EPO Advantage	570.35	1565.62
Tufts POS	926.55	2245.37
Tufts PPO Advantage	880.23	2133.10
Harvard Pilgrim	655.16	1779.41
Harvard Pilgrim Advantage	560.55	1592.78

July 1, 2012:	Individual	Family
Tufts EPO	628.87	1702.01
Tufts EPO Advantage	570.35	1565.62
Tufts POS	926.55	2245.37
Tufts PPO Advantage	880.23	2133.10
Harvard Pilgrim	655.16	1779.41
Harvard Pilgrim Advantage	560.55	1592.78

July 1, 2013:	Individual	Family
Tufts EPO	660.31	1808.27
Tufts EPO Advantage	598.87	1643.88
Tufts POS	977.51	2368.87
Tufts PPO Advantage	924.26	2239.76
Harvard Pilgrim	674.81	1832.79
Harvard Pilgrim Advantage	582.97	1656.51

July 1, 2014:	Individual	Family
Tufts EPO	676.82	1853.48
Tufts EPO Advantage	613.84	1684.98
Tufts POS	1001.95	2428.09
Tufts PPO Advantage	947.37	2295.75
Harvard Pilgrim	691.68	1878.81
Harvard Pilgrim Advantage	597.54	1697.92

ATTACHMENT I

Active/Retired	Birth date	Gender	Ind/Fam	Plan
RET	11/23/1949	Male	P1IN	POS
RET	7/18/1944	Male	P1IN	POS
RET	8/27/1949	Male	P1FA	POS
RET	6/25/1953	Male	P1FA	POS
RET	7/29/1958	Male	P1FA	POS
RET	3/2/1947	Female	P1IN	POS
RET	6/29/1941	Female	P1IN	POS
RET	10/10/1949	Male	P1FA	POS
RET	8/4/1950	Female	P1FA	POS
RET	5/19/1941	Male	P1IN	POS
RET	8/28/1925	Female	P1IN	POS
RET	10/11/1934	Female	P1IN	POS
RET	2/16/1947	Male	P1IN	POS
RET	9/17/1953	Female	P1IN	POS
RET	5/20/1951	Female	P1IN	POS
RET	10/5/1926	Male	P1IN	POS
RET	6/25/1942	Male	P1IN	POS
RET	3/31/1956	Female	P1FA	POS
RET	4/29/1954	Female	P1IN	POS
RET	2/14/1950	Female	P1IN	POS
RET	4/18/1979	Female	P1IN	POS
RET	9/10/1949	Female	P1IN	POS
RET	4/26/1953	Female	P1IN	POS
RET	11/5/1948	Female	P1IN	POS
RET	6/25/1949	Female	P1IN	POS
RET	10/25/1947	Male	P1IN	OSA
RET	8/27/1947	Male	P1IN	OSA
RET	7/22/1945	Female	P1IN	OSA
RET	9/15/1941	Female	P1IN	OSA
RET	1/24/1948	Male	P1IN	OSA
RET	5/4/1948	Male	P1FA	OSA
RET	12/21/1955	Female	P1IN	OSA
RET	9/30/1950	Male	P1FA	OSA
RET	4/8/1956	Male	P1FA	OSA
RET	2/4/1949	Male	P1FA	OSA
RET	9/9/1977	Male	P1FA	OSA
RET	12/3/1922	Female	P1IN	OSA
RET	11/28/1956	Male	P1FA	OSA
RET	10/31/1952	Male	P1FA	OSA
RET	5/6/1959	Female	P1IN	OSA
RET	12/26/1953	Female	P1IN	OSA
RET	7/15/1949	Male	P1IN	OSA
RET	5/4/1952	Female	P1FA	OSA
RET	1/31/1927	Male	P1IN	OSA



RET	1/19/1944	Male	P1IN	OSA
RET	1/12/1941	Male	P1IN	OSA
RET	11/18/1940	Male	P1IN	OSA
RET	7/13/1940	Male	P1IN	OSA
RET	7/5/1952	Female	P1IN	OSA
RET	3/26/1945	Male	P1IN	OSA
RET	1/16/1943	Male	P1IN	OSA
RET	7/7/1951	Male	P1FA	OSA
RET	11/4/1952	Male	P1FA	OSA
RET	10/7/1947	Female	P1IN	OSA
RET	5/28/1946	Female	P1IN	OSA
RET	7/14/1964	Female	P1IN	OSA
RET	1/11/1950	Female	P1IN	OSA
RET	3/2/1954	Male	P1FA	OSA
RET	10/23/1959	Female	P1IN	OSA
RET	10/22/1951	Male	P1IN	OSA
ACT	5/22/1955	Female	P1IN	EPO
ACT	6/17/1986	Male	P1IN	EPO
RET	11/5/1951	Male	P1IN	EPO
RET	8/23/1949	Male	P1FA	EPO
RET	5/18/1941	Male	P1IN	EPO
RET	12/1/1942	Male	P1FA	EPO
RET	3/29/1950	Male	P1FA	EPO
RET	3/8/1950	Male	P1IN	EPO
RET	9/8/1955	Male	P1FA	EPO
RET	3/21/1945	Male	P1IN	EPO
RET	5/3/1956	Male	P1IN	EPO
RET	9/13/1944	Male	P1IN	EPO
RET	11/13/1934	Female	P1IN	EPO
RET	8/30/1938	Male	P1IN	EPO
RET	9/15/1950	Male	P1FA	EPO
RET	12/12/1961	Male	P1IN	EPO
RET	10/26/1956	Male	P1FA	EPO
RET	1/3/1950	Female	P1FA	EPO
RET	4/5/1954	Female	P1IN	EPO
RET	2/10/1951	Male	P1FA	EPO
RET	3/1/1943	Male	P1IN	EPO
RET	9/3/1949	Male	P1IN	EPO
RET	1/24/1963	Female	P1FA	EPO
RET	9/21/1951	Male	P1FA	EPO
RET	5/30/1953	Male	P1FA	EPO
RET	1/4/1931	Male	P1IN	EPO
RET	3/28/1947	Male	P1IN	EPO
RET	7/8/1938	Male	P1IN	EPO
RET	6/14/1954	Male	P1FA	EPO
RET	2/1/1955	Male	P1FA	EPO
RET	7/11/1957	Male	P1FA	EPO

RET	2/11/1955	Female	P1IN	EPO
RET	9/10/1963	Male	P1FA	EPO
RET	4/21/1949	Male	P1IN	EPO
RET	2/22/1947	Male	P1FA	EPO
RET	9/30/1957	Female	P1IN	EPO
RET	8/2/1949	Male	P1IN	EPO
RET	12/24/1950	Female	P1IN	EPO
RET	6/13/1967	Male	P1FA	EPO
RET	12/5/1951	Male	P1IN	EPO
RET	10/21/1961	Male	P1FA	EPO
RET	2/13/1932	Male	P1IN	EPO
RET	6/12/1950	Female	P1IN	EPO
RET	4/9/1958	Female	P1IN	EPO
RET	2/27/1942	Female	P1IN	EPO
RET	4/30/1950	Male	P1IN	EPO
RET	8/21/1937	Female	P1IN	EPO
RET	11/24/1954	Male	P1FA	EPO
RET	9/16/1947	Male	P1FA	EPO
RET	5/13/1953	Male	P1FA	EPO
RET	8/22/1926	Male	P1IN	EPO
RET	10/29/1953	Female	P1IN	EPO
RET	8/30/1950	Female	P1IN	EPO
RET	10/30/1950	Male	P1IN	EPO
RET	1/3/1947	Male	P1IN	EPO
RET	1/29/1952	Female	P1IN	EPO
RET	11/16/1946	Male	P1FA	EPO
RET	9/14/1944	Male	P1IN	EPO
RET	9/9/1951	Male	P1FA	EPO
RET	8/1/1949	Male	P1FA	EPO
RET	5/6/1944	Male	P1IN	EPO
RET	5/21/1956	Male	P1FA	EPO
RET	7/24/1967	Male	P1FA	EPO
RET	12/14/1935	Male	P1IN	EPO
RET	3/31/1935	Female	P1IN	EPO
RET	7/10/1946	Male	P1FA	EPO
RET	9/18/1950	Male	P1FA	EPO
RET	5/5/1953	Female	P1IN	EPO
RET	2/27/1941	Male	P1FA	EPO
RET	6/9/1948	Female	P1IN	EPO
RET	7/22/1935	Female	P1IN	EPO
RET	1/3/1950	Female	P1FA	EPO
RET	11/2/1941	Female	P1IN	EPO
RET	11/19/1953	Male	P1FA	EPO
RET	1/28/1950	Female	P1FA	EPO
RET	11/9/1961	Male	P1FA	EPO
RET	5/12/1951	Male	P1IN	EPO
RET	7/23/1947	Male	P1IN	EPO

RET	9/11/1952	Female	P1IN	EPO
RET	12/4/1949	Male	P1FA	EPO
RET	1/8/1963	Male	P1FA	EPO
RET	8/14/1925	Female	P1IN	EPO
RET	2/14/1944	Male	P1IN	EPO
RET	2/19/1951	Male	P1FA	EPO
RET	5/13/1954	Male	P1FA	EPO
RET	2/22/1951	Female	P1IN	EPO
RET	11/18/1957	Female	P1IN	EPO
RET	12/9/1947	Female	P1IN	EPO
RET	8/4/1947	Male	P1IN	EPO
RET	12/25/1952	Female	P1IN	EPO
RET	4/3/1949	Male	P1IN	EPO
RET	1/30/1955	Male	P1IN	EPO
RET	6/6/1952	Male	P1FA	EPO
RET	2/17/1951	Female	P1FA	EPO
RET	12/14/1928	Male	P1IN	EPO
RET	6/21/1958	Male	P1FA	EPO
RET	11/10/1959	Male	P1IN	EPO
RET	5/16/1950	Male	P1FA	EPO
RET	6/6/1955	Female	P1IN	EPO
RET	5/16/1946	Male	P1IN	EPO
RET	3/4/1949	Male	P1FA	EPO
RET	1/31/1945	Female	P1IN	EPO
RET	3/9/1951	Female	P1IN	EPO
RET	9/6/1949	Male	P1FA	EPO
RET	3/30/1939	Male	P1IN	EPO
RET	11/1/1951	Male	P1FA	EPO
RET	2/27/1944	Female	P1IN	EPO
RET	3/7/1954	Male	P1FA	EPO
RET	9/29/1950	Female	P1IN	EPO
RET	8/27/1954	Male	P1FA	EPO
RET	4/7/1948	Female	P1IN	EPO
RET	2/4/1949	Male	P1FA	EPO
RET	5/27/1964	Male	P1FA	EPO
RET	10/15/1937	Male	P1IN	EPO
RET	9/8/1954	Male	P1IN	EPO
RET	8/31/1956	Male	P1FA	EPO
RET	10/10/1951	Male	P1IN	EPO
RET	4/18/1948	Male	P1IN	EPO
RET	9/8/1949	Male	P1IN	EPO
RET	4/13/1959	Male	P1IN	EPO
RET	2/5/1960	Female	P1FA	EPO
RET	10/28/1917	Male	P1IN	EPO
RET	7/10/1949	Male	P1FA	EPO
RET	3/29/1951	Female	P1IN	EPO
RET	11/19/1956	Female	P1IN	EPO

RET	8/8/1951	Female	P1FA	EPO
RET	2/25/1951	Male	P1IN	EPO
RET	4/5/1942	Male	P1IN	EPO
RET	9/30/1955	Female	P1IN	EPO
RET	2/6/1964	Female	P1FA	EPO
RET	5/12/1949	Male	P1FA	EPO
RET	12/18/1954	Female	P1IN	EPO
RET	12/18/1949	Male	P1FA	EPO
RET	11/29/1948	Male	P1IN	EPO
RET	11/7/1950	Male	P1FA	EPO
RET	2/27/1950	Female	P1IN	EPO
RET	9/8/1969	Male	P1FA	EPO
RET	4/28/1938	Male	P1IN	EPO
RET	6/16/1957	Male	P1FA	EPO
RET	8/1/1960	Female	P1IN	EPO
RET	8/9/1951	Female	P1IN	EPO
RET	3/25/1953	Female	P1IN	EPO
RET	2/17/1944	Male	P1IN	EPO
RET	4/28/1938	Male	P1IN	EPO
RET	1/30/1953	Male	P1FA	EPO
RET	8/8/1952	Male	P1FA	EPO
RET	4/16/1950	Male	P1IN	EPO
RET	9/7/1951	Female	P1IN	EPO
RET	12/24/1948	Male	P1FA	EPO
RET	10/20/1948	Female	P1IN	EPO
RET	12/9/1948	Female	P1IN	EPO
RET	3/18/1998	Female	P1IN	EPO
RET	9/9/1950	Female	P1IN	EPO
RET	10/21/1951	Female	P1IN	EPO
RET	12/21/1937	Female	P1IN	EPO
RET	4/23/1956	Female	P1IN	EPO
RET	8/3/1951	Female	P1IN	EPO
RET	9/27/1936	Female	P1IN	EPO
RET	4/9/1962	Female	P1IN	EPO
RET	12/23/1961	Female	P1FA	EPO
RET	10/2/1956	Female	P1IN	EPO
RET	9/13/1952	Female	P1IN	EPO
RET	11/4/1958	Female	P1FA	EPO
RET	10/14/1953	Female	P1IN	EPO
RET	11/23/1957	Female	P1IN	EPO
RET	4/14/1951	Male	P1IN	EPO
RET	12/29/1950	Female	P1IN	EPO
RET	3/24/1994	Male	P1IN	EPO
RET	3/7/1932	Male	P1IN	EPO
RET	5/15/1957	Female	P1IN	EPO
RET	7/10/1990	Male	P1IN	EPO
RET	4/9/1990	Female	P1IN	EPO

RET	10/28/1949	Female	P1IN	EPO
RET	9/4/2002	Female	P1IN	EPO
RET	2/22/1952	Female	P1IN	EPO
RET	8/19/1949	Female	P1IN	EPO
RET	11/1/1957	Female	P1IN	EPO
RET	3/14/1952	Female	P1IN	EPO
RET	5/8/1957	Female	P1IN	EPO
RET	9/13/1949	Male	P1IN	EPO
RET	1/18/1954	Female	P1IN	EPO
RET	5/31/1960	Female	P1FA	EPO
RET	2/28/1950	Female	P1IN	EPO
RET	1/18/1952	Female	P1IN	EPO
RET	10/23/1949	Female	P1IN	EPO
RET	4/29/1960	Male	P1FA	EPO
RET	7/30/1950	Female	P1IN	EPO
RET	12/16/1953	Female	P1IN	EPO
RET	4/2/1950	Female	P1IN	EPO
RET	5/23/1970	Female	P1FA	EPO
RET	2/28/1947	Female	P1IN	EPO
RET	9/25/1950	Female	P1FA	POS
RET	3/2/1950	Female	P1IN	POS
RET	2/1/1923	Female	P1IN	POS
RET	2/7/1950	Female	P1IN	POS
RET	12/23/1953	Female	P1FA	POS
RET	9/14/1931	Female	P1IN	POS
RET	10/29/1935	Female	P1IN	POS
RET	11/19/1949	Male	P1FA	POS
RET	1/10/1946	Female	P1IN	POS
RET	6/10/1944	Female	P1IN	POS
RET	10/4/1934	Female	P1FA	POS
RET	5/3/1923	Female	P1IN	POS
RET	8/13/1951	Male	P1FA	POS
RET	9/4/1933	Female	P1IN	POS
RET	1/8/1927	Male	P1IN	POS
RET	3/7/1951	Female	P1FA	POS
RET	2/17/1959	Female	P1FA	POS
RET	1/24/1935	Male	P1IN	POS
RET	1/13/1948	Female	P1IN	POS
RET	3/25/1947	Female	P1IN	POS
RET	7/11/1953	Male	P1FA	POS
RET	2/21/1952	Female	P1IN	POS
RET	11/27/1929	Female	P1IN	POS
RET	6/7/1921	Female	P1IN	POS
RET	12/15/1956	Female	P1FA	POS
RET	1/17/1928	Female	P1IN	POS
RET	1/23/1939	Female	P1IN	POS
RET	10/6/1950	Female	P1IN	POS

RET	11/3/1950	Male	P1FA	POS
RET	8/20/1942	Female	P1IN	POS
RET	3/8/1950	Male	P1FA	POS
RET	8/22/1933	Female	P1IN	POS
RET	11/2/1939	Female	P1IN	POS
RET	2/7/1940	Male	P1IN	POS
RET	6/1/1937	Female	P1IN	POS
RET	1/27/1950	Male	P1FA	POS
RET	1/3/1949	Female	P1IN	POS
RET	11/11/1949	Female	P1IN	POS
RET	5/28/1931	Female	P1IN	POS
RET	10/12/1956	Male	P1FA	POS
RET	12/20/1951	Female	P1FA	POS
RET	8/8/1949	Female	P1IN	POS
RET	4/25/1932	Female	P1IN	OSA
RET	12/23/1941	Male	P1IN	OSA
RET	2/16/1935	Male	P1IN	OSA
RET	9/9/1941	Female	P1IN	OSA
RET	2/19/1935	Male	P1IN	OSA
RET	10/31/1931	Female	P1IN	OSA
RET	10/24/1959	Female	P1IN	OSA
RET	7/2/1946	Female	P1IN	OSA
RET	2/8/1950	Female	P1IN	OSA
RET	2/5/1949	Female	P1IN	OSA
RET	4/20/1952	Male	P1FA	OSA
RET	7/3/1943	Female	P1IN	OSA
RET	5/29/1946	Female	P1IN	OSA
RET	5/12/1941	Female	P1IN	OSA
RET	8/26/1949	Female	P1IN	OSA
RET	3/15/1945	Female	P1IN	OSA
RET	3/15/1922	Female	P1IN	OSA
RET	3/31/1926	Female	P1IN	OSA
RET	3/6/1935	Male	P1IN	OSA
RET	11/6/1953	Female	P1FA	OSA
RET	8/18/1915	Female	P1IN	OSA
RET	8/1/1938	Female	P1IN	OSA
RET	6/25/1950	Female	P1IN	OSA
RET	1/8/1950	Female	P1IN	OSA
RET	1/1/1934	Female	P1IN	OSA
RET	10/2/1921	Female	P1IN	OSA
RET	7/24/1949	Female	P1FA	OSA
RET	6/11/1934	Male	P1IN	EPO
RET	5/8/1935	Female	P1IN	EPO
RET	8/12/1952	Female	P1IN	EPO
RET	7/1/1947	Female	P1IN	EPO
RET	10/4/1950	Female	P1IN	EPO
RET	11/4/1920	Female	P1IN	EPO

RET	7/8/1949	Female	P1IN	EPO
RET	11/22/1950	Male	P1FA	EPO
RET	7/14/1950	Female	P1IN	EPO
RET	9/15/1946	Male	P1IN	EPO
RET	10/22/1953	Male	P1FA	EPO
RET	3/18/1937	Male	P1IN	EPO
RET	8/28/1948	Female	P1IN	EPO
RET	9/23/1939	Female	P1IN	EPO
RET	9/19/1937	Male	P1FA	EPO
RET	1/25/1942	Female	P1IN	EPO
RET	12/20/1950	Female	P1FA	EPO
RET	2/5/1932	Female	P1IN	EPO
RET	8/15/1953	Female	P1FA	EPO
RET	1/2/1951	Male	P1FA	EPO
RET	7/23/1928	Female	P1IN	EPO
RET	12/16/1950	Female	P1IN	EPO
RET	3/13/1951	Female	P1IN	EPO
RET	11/15/1950	Female	P1FA	EPO
RET	10/14/1952	Female	P1FA	EPO
RET	4/21/1951	Male	P1FA	EPO
RET	7/11/1949	Male	P1IN	EPO
RET	12/27/1952	Female	P1FA	EPO
RET	9/20/1950	Female	P1FA	EPO
RET	5/2/1943	Female	P1IN	EPO
RET	3/6/1942	Female	P1IN	EPO
RET	9/9/1938	Female	P1IN	EPO
RET	7/24/1950	Male	P1IN	EPO
RET	4/20/1948	Female	P1IN	EPO
RET	11/30/1928	Female	P1IN	EPO
RET	10/12/1950	Male	P1FA	EPO
RET	11/16/1951	Male	P1FA	EPO
RET	6/7/1949	Male	P1FA	EPO
RET	11/5/1951	Female	P1IN	EPO
RET	10/29/1951	Female	P1IN	EPO
RET	11/7/1946	Male	P1IN	EPO
RET	6/9/1932	Female	P1IN	EPO
RET	4/7/1951	Female	P1IN	EPO
RET	9/21/1951	Female	P1IN	EPO
RET	12/29/1943	Male	P1FA	EPO
RET	1/8/1951	Male	P1FA	EPO
RET	7/21/1953	Male	P1FA	EPO
RET	6/30/1937	Female	P1IN	EPO
RET	10/3/1955	Female	P1IN	EPO
RET	8/24/1953	Female	P1FA	EPO
RET	7/10/1925	Male	P1FA	EPO
RET	8/25/1950	Female	P1IN	EPO
RET	7/3/1951	Male	P1IN	EPO

RET	2/3/1951	Female	P1IN	EPO
RET	8/6/1952	Female	P1FA	EPO
RET	3/14/1988	Female	P1IN	EPO
RET	7/3/1952	Female	P1IN	EPO
RET	4/8/1951	Female	P1IN	EPO
RET	9/26/1949	Male	P1IN	EPO
RET	4/24/1993	Male	P1IN	EPO
RET	7/22/1923	Female	P1IN	EPO
RET	6/20/1948	Male	P1IN	EPO
RET	9/7/1949	Male	P1IN	EPO
RET	7/7/1951	Female	P1IN	EPO
RET	12/23/1953	Male	P1IN	EPO
RET	8/22/1953	Female	P1IN	EPO
RET	11/3/1951	Male	P1FA	EPO
RET	4/4/1952	Female	P1FA	EPO
RET	7/7/1952	Male	P1FA	EPO
RET	10/28/1953	Female	P1IN	EPO
RET	6/19/1949	Male	P1FA	EPO
RET	3/23/1954	Male	P1FA	EPO
RET	2/22/1950	Male	P1FA	EPO
RET	9/20/1951	Male	P1FA	EPO
RET	1/21/1956	Female	P1FA	EPO
RET	11/24/1956	Male	P1FA	EPO
RET	4/3/1950	Female	P1IN	EPO
RET	12/16/1964	Male	P1FA	EPO
RET	6/2/1957	Male	P1IN	EPO
RET	5/8/1951	Male	P1IN	EPO
RET	8/1/1949	Female	P1IN	EPO
RET	11/20/1949	Female	P1FA	EPO
RET	7/4/1951	Female	P1FA	EPO
RET	7/8/1956	Female	P1FA	EPO
RET	9/12/1952	Male	P1FA	EPO
RET	6/17/1947	Male	P1FA	EPO
RET	5/29/1945	Male	P1FA	EPO
RET	2/8/1936	Female	P1IN	EPO
RET	4/28/1951	Male	P1IN	EPO
RET	1/7/1955	Female	P1FA	EPO
RET	1/21/1953	Female	P1IN	EPO
ACT	11/14/1982	Male	P1IN	EPO
ACT	5/26/1962	Male	P1FA	EPO
ACT	3/13/1971	Male	P1IN	EPO
ACT	6/28/1975	Male	P1FA	EPO
ACT	7/23/1949	Male	P1FA	EPO
ACT	3/13/1955	Male	P1FA	EPO
ACT	7/13/1973	Male	P1FA	EPO
ACT	1/15/1970	Male	P1FA	EPO
ACT	2/26/1958	Male	P1FA	EPO



ACT	9/15/1958	Male	P1FA	EPO
ACT	3/4/1957	Male	P1FA	EPO
ACT	12/27/1970	Male	P1FA	EPO
ACT	7/20/1964	Male	P1FA	EPO
ACT	12/11/1973	Male	P1IN	EPO
ACT	3/30/1961	Male	P1FA	EPO
ACT	1/27/1981	Male	P1FA	EPO
ACT	4/15/1959	Male	P1FA	EPO
ACT	4/3/1959	Male	P1FA	EPO
ACT	3/18/1981	Male	P1IN	EPO
ACT	12/29/1978	Male	P1IN	EPO
ACT	2/1/1962	Male	P1IN	EPO
ACT	3/9/1958	Male	P1FA	EPO
ACT	7/28/1949	Male	P1FA	EPO
ACT	9/27/1947	Male	P1FA	EPO
ACT	8/6/1973	Male	P1FA	EPO
ACT	10/6/1960	Male	P1FA	EPO
ACT	7/13/1964	Male	P1IN	EPO
ACT	7/29/1976	Male	P1FA	EPO
ACT	5/19/1974	Male	P1FA	EPO
ACT	10/3/1977	Male	P1FA	EPO
ACT	8/15/1979	Male	P1FA	EPO
ACT	7/14/1981	Male	P1IN	EPO
ACT	5/15/1968	Female	P1IN	EPO
ACT	12/20/1974	Male	P1FA	EPO
ACT	7/19/1957	Male	P1FA	EPO
ACT	2/16/1971	Male	P1FA	EPO
ACT	1/18/1967	Male	P1FA	EPO
ACT	9/10/1954	Male	P1FA	EPO
ACT	4/15/1972	Male	P1FA	EPO
ACT	7/18/1972	Male	P1FA	EPO
ACT	10/12/1977	Male	P1IN	EPO
ACT	4/14/1968	Male	P1FA	EPO
ACT	2/14/1952	Male	P1IN	EPO
ACT	3/1/1969	Male	P1FA	EPO
ACT	12/10/1958	Male	P1IN	EPO
ACT	3/8/1953	Male	P1FA	EPO
ACT	11/27/1962	Male	P1FA	EPO
ACT	10/7/1971	Male	P1FA	EPO
ACT	4/21/1958	Male	P1IN	EPO
ACT	5/25/1981	Male	P1IN	EPO
ACT	1/11/1960	Male	P1FA	EPO
ACT	12/22/1967	Male	P1FA	EPO
ACT	6/11/1980	Male	P1FA	EPO
ACT	4/8/1977	Male	P1FA	EPO
ACT	10/2/1977	Male	P1FA	EPO
ACT	2/7/1962	Male	P1FA	EPO

ACT	8/30/1969	Male	P1FA	EPO
ACT	3/12/1962	Male	P1FA	EPO
ACT	3/23/1957	Male	P1FA	EPO
ACT	7/26/1956	Male	P1FA	EPO
ACT	1/29/1963	Male	P1FA	EPO
ACT	10/9/1957	Male	P1IN	EPO
ACT	5/7/1959	Male	P1FA	EPO
ACT	6/13/1969	Male	P1FA	EPO
ACT	8/21/1970	Male	P1FA	EPO
ACT	2/14/1976	Male	P1FA	EPO
ACT	11/3/1963	Male	P1FA	EPO
ACT	10/2/1979	Male	P1FA	EPO
ACT	7/15/1955	Male	P1IN	EPO
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ACT	1/15/1965	Male	P1FA	EPO
ACT	12/29/1955	Male	P1IN	EPO
ACT	4/15/1969	Male	P1IN	EPO
ACT	5/4/1963	Male	P1FA	EPO
ACT	1/30/1964	Male	P1FA	EPO
ACT	10/12/1958	Male	P1FA	EPO
ACT	4/17/1970	Male	P1FA	EPO
ACT	9/22/1956	Male	P1FA	EPO
ACT	2/28/1960	Male	P1FA	EPO
ACT	6/11/1986	Male	P1IN	EPO
ACT	7/29/1980	Male	P1FA	EPO
ACT	12/15/1989	Male	P1IN	EPO
ACT	7/31/1985	Male	P1FA	EPO
ACT	10/19/1984	Male	P1IN	EPO
ACT	4/30/1984	Male	P1FA	EPO
ACT	4/8/1975	Male	P1FA	EPO
ACT	5/12/1987	Male	P1IN	EPO
ACT	6/12/1984	Male	P1IN	EPO
ACT	8/15/1983	Male	P1FA	EPO
ACT	9/17/1980	Male	P1IN	EPO
ACT	10/18/1981	Male	P1IN	EPO
ACT	4/16/1981	Male	P1FA	EPO
ACT	3/2/1981	Male	P1FA	EPO
ACT	5/13/1985	Male	P1IN	EPO
ACT	8/16/1982	Male	P1IN	EPO
ACT	8/6/1985	Male	P1IN	EPO
ACT	11/29/1984	Male	P1IN	EPO
ACT	3/26/1981	Male	P1IN	EPO
ACT	10/26/1986	Male	P1FA	EPO
ACT	7/3/1976	Male	P1FA	EPO
ACT	11/14/1973	Female	P1IN	EPO

ACT	1/20/1986	Male	P1IN	EPO
ACT	3/29/1978	Male	P1FA	EPO
ACT	9/25/1976	Male	P1FA	EPO
ACT	5/10/1983	Male	P1IN	EPO
ACT	10/19/1978	Male	P1IN	EPO
ACT	9/19/1983	Male	P1IN	EPO
ACT	5/19/1986	Male	P1FA	EPO
ACT	6/25/1984	Male	P1IN	EPO
ACT	8/1/1981	Male	P1IN	EPO
ACT	7/23/1985	Male	P1FA	EPO
ACT	10/7/1975	Male	P1FA	EPO
ACT	10/22/1988	Male	P1IN	EPO
ACT	4/25/1984	Male	P1IN	EPO
ACT	2/10/1986	Male	P1IN	EPO
ACT	3/13/1986	Male	P1IN	EPO
ACT	9/2/1966	Male	P1FA	EPO
ACT	10/24/1971	Male	P1IN	EPO
ACT	8/27/1975	Male	P1FA	EPO
ACT	2/16/1957	Male	P1FA	EPO
ACT	8/5/1973	Male	P1FA	EPO
ACT	12/8/1969	Male	P1IN	EPO
ACT	5/17/1976	Male	P1IN	EPO
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ACT	4/15/1959	Male	P1FA	EPO
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ACT	5/16/1971	Male	P1FA	EPO
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ACT	2/6/1976	Male	P1FA	EPO
ACT	8/10/1965	Male	P1FA	EPO
ACT	3/23/1971	Male	P1FA	EPO
ACT	9/11/1957	Male	P1FA	EPO
ACT	10/9/1985	Male	P1IN	EPO
ACT	12/22/1951	Male	P1FA	EPO
ACT	6/25/1957	Male	P1FA	EPO
ACT	4/21/1958	Female	P1IN	EPO
ACT	1/18/1964	Male	P1FA	EPO
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ACT	9/13/1970	Male	P1FA	EPO
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ACT	2/3/1964	Male	P1FA	EPO
ACT	7/9/1982	Male	P1IN	EPO
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ACT	8/2/1969	Male	P1FA	EPO
ACT	2/5/1957	Male	P1FA	EPO
ACT	2/19/1956	Female	P1IN	EPO
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ACT	12/13/1975	Male	P1FA	EPO
ACT	3/17/1955	Male	P1FA	EPO
ACT	11/1/1970	Male	P1FA	EPO
ACT	4/20/1978	Male	P1FA	EPO
ACT	9/7/1957	Male	P1FA	EPO
ACT	11/14/1973	Male	P1FA	EPO
ACT	9/9/1967	Male	P1FA	EPO
ACT	2/3/1983	Female	P1IN	EPO
ACT	1/7/1965	Male	P1FA	EPO
ACT	2/3/1973	Female	P1IN	EPO
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ACT	9/21/1957	Male	P1IN	EPO
ACT	1/1/1973	Male	P1FA	EPO
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ACT	8/21/1972	Male	P1IN	EPO
ACT	10/29/1969	Male	P1FA	EPO
ACT	9/10/1968	Male	P1FA	EPO
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ACT	3/28/1955	Male	P1IN	EPO
ACT	3/9/1956	Male	P1FA	EPO
ACT	11/22/1965	Male	P1FA	EPO
ACT	5/16/1961	Male	P1FA	EPO
ACT	2/9/1974	Male	P1FA	EPO
ACT	10/9/1948	Male	P1FA	EPO
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ACT	8/25/1964	Male	P1IN	EPO
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ACT	8/17/1963	Male	P1FA	EPO
ACT	9/18/1968	Male	P1IN	EPO
ACT	12/25/1954	Male	P1FA	EPO
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ACT	9/21/1959	Male	P1FA	EPO
ACT	7/15/1959	Male	P1FA	EPO
ACT	8/28/1971	Male	P1IN	EPO
ACT	9/9/1944	Male	P1FA	EPO
ACT	11/14/1950	Male	P1FA	EPO
ACT	7/30/1965	Male	P1IN	EPO
ACT	2/7/1954	Male	P1FA	EPO
ACT	1/3/1964	Male	P1IN	EPO
ACT	5/29/1978	Male	P1IN	EPO

ACT	9/29/1939	Male	P1IN	EPO
ACT	9/28/1954	Male	P1FA	EPO
ACT	7/16/1966	Male	P1IN	EPO
ACT	6/29/1973	Male	P1FA	EPO
ACT	12/20/1956	Male	P1FA	EPO
ACT	4/27/1954	Male	P1FA	EPO
ACT	4/30/1971	Male	P1FA	EPO
ACT	12/20/1946	Male	P1IN	EPO
ACT	11/17/1970	Male	P1FA	EPO
ACT	10/29/1977	Male	P1FA	EPO
ACT	4/30/1953	Male	P1FA	EPO
ACT	4/27/1955	Male	P1FA	EPO
ACT	4/18/1954	Male	P1FA	EPO
ACT	7/20/1986	Female	P1IN	EPO
ACT	1/30/1975	Female	P1FA	EPO
ACT	6/16/1983	Male	P1FA	EPO
ACT	3/21/1969	Male	P1FA	EPO
ACT	2/24/1982	Male	P1FA	EPO
ACT	6/18/1967	Male	P1FA	EPO
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ACT	3/29/1983	Male	P1FA	EPO
ACT	4/13/1963	Male	P1FA	EPO
ACT	8/18/1954	Male	P1IN	EPO
ACT	8/10/1979	Male	P1FA	EPO
ACT	3/20/1986	Male	P1FA	EPO
ACT	9/24/1946	Male	P1FA	EPO
ACT	8/11/1986	Male	P1IN	EPO
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ACT	2/14/1986	Male	P1IN	EPO
ACT	8/11/1962	Male	P1IN	EPO
ACT	8/10/1957	Male	P1IN	EPO
ACT	6/16/1966	Male	P1FA	EPO
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ACT	8/23/1980	Male	P1IN	EPO
ACT	2/5/1978	Male	P1IN	EPO
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ACT	12/19/1976	Male	P1FA	EPO
ACT	9/29/1985	Male	P1IN	EPO
ACT	10/7/1955	Male	P1FA	EPO
ACT	12/22/1970	Male	P1FA	EPO
ACT	1/19/1966	Male	P1FA	EPO

ACT	2/27/1958	Male	P1FA	EPO
ACT	4/15/1952	Male	P1FA	EPO
ACT	12/10/1958	Male	P1FA	EPO
ACT	6/18/1973	Male	P1FA	EPO
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ACT	4/11/1979	Female	P1IN	EPO
ACT	12/17/1956	Male	P1FA	EPO
ACT	4/26/1963	Male	P1IN	EPO
ACT	3/23/1960	Male	P1FA	EPO
ACT	10/25/1959	Male	P1FA	EPO
ACT	11/15/1976	Male	P1IN	EPO
ACT	7/25/1979	Male	P1IN	EPO
ACT	5/22/1955	Male	P1FA	EPO
ACT	7/11/1955	Male	P1FA	EPO
ACT	5/22/1955	Male	P1FA	EPO
ACT	11/24/1950	Male	P1FA	EPO
ACT	12/26/1969	Male	P1IN	EPO
ACT	7/17/1968	Male	P1FA	EPO
ACT	6/17/1964	Male	P1FA	EPO
ACT	8/19/1961	Male	P1FA	EPO
ACT	5/29/1967	Male	P1FA	EPO
ACT	5/11/1961	Male	P1FA	EPO
ACT	10/20/1957	Male	P1FA	EPO
ACT	12/12/1956	Male	P1FA	EPO
ACT	2/22/1948	Male	P1IN	EPO
ACT	9/1/1974	Male	P1FA	EPO
ACT	2/24/1949	Male	P1FA	EPO
ACT	7/11/1955	Male	P1FA	EPO
ACT	2/29/1944	Male	P1FA	EPO
ACT	1/30/1951	Female	P1IN	EPO
ACT	4/9/1944	Male	P1FA	EPO
ACT	4/24/1951	Male	P1IN	EPO
ACT	8/28/1949	Male	P1FA	EPO
ACT	6/15/1948	Male	P1IN	EPO
ACT	12/12/1972	Male	P1FA	EPO
ACT	6/7/1968	Male	P1FA	EPO
ACT	11/30/1960	Male	P1FA	EPO
ACT	12/26/1965	Male	P1FA	EPO
ACT	9/21/1954	Female	P1FA	EPO
ACT	12/5/1953	Female	P1FA	EPO
ACT	12/20/1947	Female	P1FA	EPO
ACT	7/5/1947	Male	P1FA	EPO
ACT	4/18/1973	Male	P1FA	EPO
ACT	8/25/1943	Male	P1FA	EPO

ACT	1/2/1959	Female	P1FA	EPO
ACT	4/25/1952	Female	P1IN	EPO
ACT	10/17/1946	Female	P1FA	EPO
ACT	6/19/1964	Female	P1FA	EPO
ACT	12/3/1961	Female	P1FA	EPO
ACT	1/8/1955	Female	P1FA	EPO
ACT	7/9/1956	Female	P1FA	EPO
ACT	7/25/1961	Female	P1FA	EPO
ACT	11/16/1964	Female	P1FA	EPO
ACT	6/8/1954	Female	P1IN	EPO
ACT	11/26/1953	Female	P1FA	EPO
ACT	12/5/1959	Female	P1FA	EPO
ACT	11/6/1943	Female	P1IN	EPO
ACT	5/12/1956	Female	P1FA	EPO
ACT	7/26/1958	Female	P1IN	EPO
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RET	1/26/1951	Male	P1FA	EPO
RET	11/27/1953	Female	P1IN	EPO
RET	8/23/1949	Female	P1IN	EPO
RET	12/24/1956	Male	P1FA	EPO
RET	6/13/1953	Male	P1IN	EPO
RET	5/23/1955	Male	P1FA	EPO
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RET	2/2/1954	Male	P1IN	EPO
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ACT	5/21/1969	Female	P1FA	EPO
ACT	9/23/1955	Male	P1IN	EPO
ACT	2/6/1960	Female	P1FA	EPO
ACT	12/23/1952	Male	P1FA	EPO
ACT	9/29/1955	Male	P1FA	EPO
ACT	10/26/1963	Male	P1FA	EPO
ACT	2/11/1951	Female	P1FA	EPO
ACT	4/27/1968	Female	P1IN	EPO
ACT	10/6/1965	Male	P1FA	EPO
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ACT	3/2/1959	Male	P1FA	EPO
ACT	4/21/1963	Male	P1FA	EPO
ACT	5/7/1955	Male	P1FA	EPO
ACT	6/1/1961	Male	P1IN	EPO
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ACT	9/16/1947	Female	P1IN	EPO
ACT	11/2/1944	Female	P1FA	EPO
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ACT	1/28/1965	Male	P1FA	EPO
ACT	5/5/1955	Female	P1FA	EPO
ACT	11/2/1969	Female	P1IN	EPO
ACT	7/28/1948	Female	P1IN	EPO
ACT	1/7/1962	Female	P1FA	EPO
ACT	9/22/1953	Female	P1IN	EPO
ACT	8/14/1965	Female	P1FA	EPO
ACT	7/18/1961	Female	P1FA	EPO
ACT	6/21/1971	Male	P1FA	EPO
ACT	10/6/1976	Male	P1FA	EPO
ACT	9/13/1949	Male	P1FA	EPO
ACT	6/14/1954	Male	P1FA	EPO
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ACT	12/27/1951	Female	P1IN	EPO
ACT	1/7/1966	Male	P1FA	EPO
ACT	3/9/1961	Female	P1FA	EPO
ACT	5/29/1961	Male	P1FA	EPO
ACT	12/14/1956	Male	P1IN	EPO
ACT	10/1/1948	Male	P1IN	EPO
ACT	3/16/1959	Male	P1FA	EPO
ACT	5/27/1953	Female	P1FA	EPO
ACT	11/9/1951	Male	P1FA	EPO
ACT	12/14/1965	Male	P1FA	EPO
ACT	12/6/1960	Male	P1FA	EPO
ACT	6/24/1980	Female	P1FA	EPO
ACT	9/29/1964	Male	P1FA	EPO
ACT	1/24/1949	Female	P1IN	EPO
ACT	11/28/1962	Female	P1FA	EPO
ACT	12/19/1980	Male	P1FA	EPO
ACT	12/5/1977	Male	P1FA	EPO
ACT	6/23/1983	Female	P1IN	EPO
ACT	8/26/1961	Female	P1FA	EPO
ACT	12/3/1981	Male	P1IN	EPO
ACT	7/31/1981	Male	P1FA	EPO
ACT	9/25/1980	Male	P1FA	EPO
ACT	1/31/1983	Female	P1IN	EPO
ACT	6/8/1958	Female	P1FA	EPO
ACT	8/22/1986	Male	P1IN	EPO
ACT	3/12/1962	Female	P1FA	EPO
ACT	10/9/1946	Female	P1FA	EPO
ACT	5/4/1968	Female	P1FA	EPO

ACT	2/4/1975	Female	P1IN	EPO
ACT	11/14/1949	Female	P1FA	EPO
ACT	10/3/1952	Female	P1FA	EPO
ACT	11/24/1958	Female	P1IN	EPO
ACT	2/19/1980	Female	P1IN	EPO
ACT	7/5/1951	Female	P1IN	EPO
ACT	5/4/1967	Female	P1IN	EPO
ACT	7/14/1950	Male	P1FA	EPO
ACT	3/11/1954	Female	P1FA	EPO
ACT	1/28/1950	Female	P1FA	EPO
ACT	11/25/1962	Female	P1FA	EPO
ACT	8/31/1939	Female	P1IN	EPO
ACT	4/14/1962	Female	P1FA	EPO
ACT	9/13/1957	Female	P1FA	EPO
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ACT	2/18/1966	Female	P1IN	EPO
ACT	12/15/1950	Male	P1FA	EPO
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ACT	11/18/1955	Female	P1FA	EPO
ACT	2/4/1959	Female	P1IN	EPO
ACT	5/31/1952	Female	P1IN	EPO
ACT	4/15/1961	Female	P1IN	EPO
ACT	7/27/1949	Male	P1IN	EPO
ACT	11/20/1960	Female	P1FA	EPO
ACT	3/5/1980	Male	P1IN	EPO
ACT	4/1/1971	Female	P1FA	EPO
ACT	12/28/1970	Male	P1IN	EPO
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ACT	6/30/1954	Female	P1FA	EPO
ACT	2/17/1954	Female	P1IN	EPO
ACT	10/27/1950	Female	P1IN	EPO
ACT	5/19/1958	Female	P1FA	EPO
ACT	10/21/1961	Female	P1IN	EPO
ACT	10/18/1963	Female	P1FA	EPO
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ACT	2/27/1965	Male	P1FA	EPO
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ACT	5/7/1959	Male	P1IN	EPO
ACT	7/30/1969	Female	P1FA	EPO
ACT	8/8/1959	Female	P1FA	EPO
ACT	9/18/1939	Female	P1FA	EPO
ACT	4/14/1967	Female	P1IN	EPO
ACT	6/18/1964	Female	P1FA	EPO

ACT	2/13/1979	Female	P1IN	EPO
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ACT	11/10/1948	Female	P1FA	EPO
ACT	10/19/1962	Male	P1IN	EPO
ACT	7/25/1951	Female	P1IN	EPO
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ACT	7/9/1948	Female	P1IN	EPO
ACT	5/10/1958	Female	P1IN	EPO
ACT	10/2/1951	Female	P1IN	EPO
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ACT	7/10/1968	Female	P1FA	EPO
ACT	3/31/1978	Male	P1IN	EPO
ACT	2/12/1958	Male	P1FA	EPO
ACT	4/1/1946	Female	P1FA	EPO
ACT	3/11/1973	Male	P1FA	EPO
ACT	1/3/1943	Female	P1IN	EPO
ACT	7/12/1959	Male	P1FA	EPO
ACT	4/27/1949	Male	P1IN	EPO
ACT	12/19/1975	Male	P1FA	EPO
ACT	6/25/1988	Female	P1IN	EPO
ACT	5/27/1989	Female	P1IN	EPO
ACT	2/9/1982	Female	P1FA	EPO
ACT	9/14/1984	Male	P1IN	EPO
ACT	6/24/1985	Female	P1IN	EPO
ACT	12/8/1970	Male	P1FA	EPO
ACT	4/25/1966	Female	P1FA	EPO
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ACT	11/30/1980	Female	P1IN	EPO
ACT	9/22/1952	Female	P1IN	EPO
ACT	1/27/1988	Female	P1IN	EPO
ACT	5/3/1986	Female	P1FA	EPO
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ACT	12/29/1982	Male	P1IN	EPO
ACT	2/5/1986	Female	P1IN	EPO
ACT	2/28/1984	Male	P1IN	EPO
ACT	8/2/1985	Female	P1IN	EPO
ACT	7/20/1979	Male	P1IN	EPO
ACT	2/14/1982	Female	P1IN	EPO
ACT	11/2/1958	Female	P1FA	EPO
ACT	8/4/1978	Male	P1IN	EPO
ACT	1/25/1985	Female	P1IN	EPO
ACT	5/14/1962	Female	P1FA	EPO
ACT	6/19/1963	Female	P1FA	EPO
ACT	7/17/1981	Female	P1IN	EPO
ACT	5/8/1986	Female	P1IN	EPO
ACT	2/15/1949	Male	P1IN	EPO

ACT	2/9/1989	Female	P1IN	EPO
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ACT	11/29/1985	Female	P1IN	EPO
ACT	5/1/1963	Female	P1FA	EPO
ACT	7/6/1976	Female	P1IN	EPO
ACT	12/7/1983	Female	P1IN	EPO
ACT	4/14/1987	Male	P1IN	EPO
ACT	4/2/1955	Female	P1FA	EPO
ACT	1/19/1940	Female	P1IN	EPO
ACT	5/17/1985	Male	P1IN	EPO
ACT	12/7/1953	Female	P1FA	EPO
ACT	1/31/1952	Female	P1FA	EPO
ACT	12/17/1968	Female	P1FA	EPO
RET	1/22/1954	Female	P1FA	OSA
RET	2/26/1957	Male	P1FA	OSA
ACT	9/16/1968	Male	P1FA	OSA
ACT	12/27/1965	Male	P1IN	EPO
ACT	7/8/1942	Female	P1IN	EPO
ACT	9/4/1961	Female	P1FA	EPO
ACT	5/25/1936	Female	P1IN	EPO
ACT	12/17/1951	Female	P1IN	EPO
ACT	11/21/1981	Female	P1FA	EPO
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ACT	2/15/1947	Male	P1IN	EPO
ACT	6/28/1982	Female	P1IN	EPO
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ACT	7/15/1949	Female	P1IN	EPO
ACT	2/11/1975	Female	P1FA	EPO
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ACT	11/8/1962	Male	P1FA	EPO
ACT	5/29/1955	Female	P1FA	EPO
ACT	8/1/1951	Female	P1IN	EPO
ACT	8/11/1972	Female	P1IN	EPO
ACT	4/8/1977	Female	P1FA	EPO
ACT	3/15/1956	Female	P1IN	EPO
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ACT	2/14/1971	Female	P1FA	EPO
ACT	2/5/1962	Male	P1FA	EPO
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ACT	8/14/1966	Female	P1FA	EPO
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ACT	9/19/1967	Female	P1FA	EPO
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ACT	3/24/1968	Female	P1FA	EPO
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ACT	9/7/1966	Female	P1FA	EPO
ACT	1/23/1970	Male	P1IN	EPO
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ACT	5/1/1967	Male	P1IN	EPO
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ACT	5/4/1975	Male	P1FA	EPO
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ACT	9/2/1982	Male	P1IN	EPO
ACT	2/23/1973	Female	P1FA	EPO
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ACT	8/7/1956	Female	P1IN	EPO
ACT	1/11/1967	Female	P1FA	EPO
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ACT	5/23/1970	Female	P1FA	EPO

ACT	12/3/1980	Male	P1FA	EPO
ACT	11/2/1972	Female	P1FA	EPO
ACT	7/17/1977	Male	P1FA	EPO
ACT	8/30/1967	Female	P1FA	EPO
ACT	4/26/1951	Female	P1IN	EPO
ACT	3/11/1954	Female	P1FA	EPO
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ACT	6/2/1947	Female	P1FA	EPO
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ACT	8/1/1972	Female	P1FA	EPO
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ACT	3/10/1960	Male	P1FA	EPO
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ACT	2/9/1952	Male	P1FA	EPO
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ACT	5/25/1962	Male	P1FA	EPO
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ACT	3/15/1972	Female	P1IN	EPO
ACT	8/17/1945	Female	P1IN	EPO
ACT	3/25/1970	Female	P1FA	EPO
ACT	10/29/1958	Male	P1FA	EPO
ACT	8/7/1963	Female	P1FA	EPO

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ACT	9/28/1947	Female	P1IN	EPO
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ACT	3/3/1968	Female	P1IN	EPO
ACT	7/4/1975	Female	P1FA	EPO
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ACT	1/25/1975	Male	P1IN	EPO
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ACT	8/5/1967	Male	P1IN	EPO
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ACT	3/15/1973	Female	P1FA	EPO
ACT	10/16/1962	Male	P1FA	EPO
ACT	4/19/1975	Female	P1FA	EPO
ACT	10/15/1974	Male	P1FA	EPO
ACT	10/22/1959	Female	P1FA	EPO

ACT	2/6/1950	Female	P1FA	EPO
ACT	10/22/1974	Female	P1FA	EPO
ACT	4/4/1970	Female	P1IN	EPO
ACT	8/14/1950	Female	P1FA	EPO
ACT	5/26/1965	Male	P1FA	EPO
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ACT	12/5/1966	Female	P1IN	EPO
ACT	1/22/1954	Male	P1FA	EPO
ACT	3/6/1959	Male	P1IN	EPO
ACT	11/21/1944	Male	P1FA	EPO
ACT	6/10/1957	Female	P1FA	EPO
ACT	9/14/1971	Female	P1FA	EPO
ACT	11/12/1969	Male	P1FA	EPO
ACT	10/2/1956	Male	P1FA	EPO



ACT	3/21/1963	Female	P1IN	EPO
ACT	9/24/1963	Male	P1FA	EPO
ACT	11/8/1974	Female	P1FA	EPO
ACT	2/3/1961	Female	P1FA	EPO
ACT	1/13/1975	Female	P1FA	EPO
ACT	11/23/1977	Female	P1FA	EPO
ACT	9/24/1963	Male	P1FA	EPO
ACT	5/4/1961	Male	P1IN	EPO
ACT	11/30/1953	Female	P1FA	EPO
ACT	6/10/1949	Female	P1FA	EPO
ACT	8/26/1969	Female	P1FA	EPO
ACT	8/19/1963	Female	P1FA	EPO
ACT	4/5/1949	Female	P1FA	EPO
ACT	6/27/1950	Female	P1FA	EPO
ACT	3/30/1979	Female	P1IN	EPO
ACT	2/17/1957	Female	P1FA	EPO
ACT	10/23/1979	Male	P1FA	EPO
ACT	9/27/1971	Male	P1IN	EPO
ACT	6/12/1964	Male	P1FA	EPO
ACT	7/16/1977	Female	P1FA	EPO
ACT	8/15/1976	Female	P1FA	EPO
ACT	11/2/1964	Male	P1IN	EPO
ACT	9/1/1966	Female	P1FA	EPO
ACT	1/28/1958	Female	P1FA	EPO
ACT	8/17/1977	Male	P1IN	EPO
ACT	9/6/1947	Female	P1FA	EPO
ACT	12/9/1961	Male	P1FA	EPO
ACT	12/3/1964	Female	P1IN	EPO
ACT	9/30/1966	Male	P1IN	EPO
ACT	2/18/1973	Female	P1FA	EPO
ACT	5/13/1976	Female	P1FA	EPO
ACT	2/28/1959	Female	P1FA	EPO
ACT	7/28/1960	Female	P1FA	EPO
ACT	6/21/1951	Male	P1IN	EPO
ACT	3/28/1955	Female	P1FA	EPO
ACT	5/26/1959	Female	P1FA	EPO
ACT	9/19/1971	Female	P1FA	EPO
ACT	6/16/1941	Female	P1IN	EPO
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ACT	10/11/1956	Female	P1FA	EPO
ACT	11/20/1977	Female	P1FA	EPO
ACT	5/22/1972	Female	P1FA	EPO
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ACT	5/3/1980	Female	P1FA	EPO
ACT	7/27/1973	Female	P1FA	EPO

ACT	2/19/1957	Male	P1FA	EPO
ACT	9/19/1958	Female	P1FA	EPO
ACT	4/20/1957	Female	P1IN	EPO
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ACT	9/13/1981	Female	P1IN	EPO
ACT	4/29/1960	Female	P1FA	EPO
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ACT	5/28/1986	Female	P1IN	EPO
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ACT	6/16/1986	Female	P1FA	EPO
ACT	4/22/1988	Female	P1IN	EPO
ACT	8/5/1985	Female	P1IN	EPO
ACT	5/10/1982	Male	P1FA	EPO
ACT	4/8/1971	Male	P1FA	EPO
ACT	11/25/1986	Female	P1IN	EPO
ACT	7/13/1964	Female	P1FA	EPO
ACT	2/16/1953	Female	P1FA	EPO
ACT	11/26/1977	Female	P1IN	EPO
ACT	9/21/1981	Female	P1FA	EPO
ACT	2/25/1985	Female	P1IN	EPO
ACT	12/24/1952	Female	P1FA	EPO
ACT	2/15/1961	Female	P1FA	EPO
ACT	5/22/1977	Female	P1FA	EPO
ACT	8/3/1984	Female	P1FA	EPO
ACT	6/4/1984	Female	P1IN	EPO
ACT	10/15/1982	Female	P1FA	EPO
ACT	7/7/1985	Female	P1IN	EPO
ACT	9/19/1987	Female	P1IN	EPO
ACT	6/26/1983	Female	P1IN	EPO
ACT	7/12/1980	Female	P1IN	EPO
ACT	12/11/1983	Female	P1IN	EPO
ACT	11/14/1982	Female	P1IN	EPO
ACT	5/30/1988	Female	P1IN	EPO
ACT	5/22/1988	Female	P1IN	EPO

ACT	6/5/1980	Female	P1IN	EPO
ACT	4/8/1981	Female	P1IN	EPO
ACT	6/18/1973	Female	P1FA	EPO
ACT	10/13/1975	Male	P1FA	EPO
ACT	10/15/1983	Female	P1FA	EPO
ACT	9/26/1983	Female	P1IN	EPO
ACT	4/10/1978	Male	P1FA	EPO
ACT	4/14/1953	Female	P1FA	EPO
ACT	7/24/1980	Female	P1IN	EPO
ACT	3/6/1985	Female	P1IN	EPO
ACT	7/13/1971	Male	P1IN	EPO
ACT	4/13/1982	Female	P1IN	EPO
ACT	3/12/1988	Male	P1IN	EPO
ACT	5/31/1984	Female	P1IN	EPO
ACT	5/27/1973	Female	P1IN	EPO
ACT	2/9/1988	Male	P1IN	EPO
ACT	4/27/1957	Female	P1FA	EPO
ACT	2/3/1978	Female	P1IN	EPO
ACT	3/13/1969	Female	P1IN	EPO
ACT	12/21/1990	Female	P1IN	EPO
ACT	11/30/1980	Female	P1IN	EPO
ACT	3/5/1985	Female	P1IN	EPO
ACT	9/27/1972	Female	P1FA	EPO
ACT	12/1/1954	Female	P1FA	EPO
ACT	4/20/1982	Female	P1IN	EPO
ACT	9/23/1981	Female	P1IN	EPO
ACT	10/7/1983	Female	P1IN	EPO
ACT	9/6/1984	Female	P1IN	EPO
ACT	3/16/1959	Female	P1FA	EPO
ACT	4/12/1989	Female	P1IN	EPO
ACT	5/22/1985	Female	P1IN	EPO
ACT	12/29/1987	Female	P1FA	EPO
ACT	5/29/1981	Female	P1FA	EPO
ACT	4/29/1980	Female	P1FA	EPO
ACT	4/10/1974	Female	P1FA	EPO
ACT	11/11/1951	Female	P1IN	EPO
ACT	12/14/1985	Female	P1IN	EPO
ACT	7/10/1984	Female	P1IN	EPO
ACT	7/21/1980	Male	P1FA	EPO
ACT	1/27/1986	Female	P1IN	EPO
ACT	10/6/1985	Male	P1FA	EPO
ACT	11/30/1981	Female	P1IN	EPO
ACT	9/8/1973	Female	P1IN	EPO
ACT	4/22/1976	Male	P1FA	EPO
ACT	10/18/1977	Male	P1IN	EPO
ACT	6/6/1982	Female	P1IN	EPO
ACT	4/3/1966	Male	P1FA	EPO

ACT	6/4/1960	Female	P1FA	EPO
ACT	10/19/1987	Female	P1IN	EPO
ACT	6/23/1981	Female	P1IN	EPO
ACT	10/5/1979	Male	P1FA	EPO
ACT	8/20/1982	Female	P1IN	EPO
ACT	2/14/1988	Female	P1IN	EPO
ACT	10/25/1987	Female	P1IN	EPO
ACT	5/27/1988	Female	P1IN	EPO
ACT	4/25/1987	Male	P1FA	EPO
ACT	5/17/1962	Female	P1FA	EPO
ACT	8/23/1981	Female	P1IN	EPO
ACT	9/23/1964	Female	P1FA	EPO
ACT	7/26/1987	Female	P1IN	EPO
ACT	6/26/1981	Female	P1IN	EPO
ACT	8/31/1962	Female	P1IN	EPO
ACT	4/3/1967	Female	P1FA	EPO
ACT	5/6/1981	Male	P1FA	EPO
ACT	5/15/1987	Male	P1IN	EPO
ACT	8/26/1979	Female	P1FA	EPO
ACT	7/27/1974	Female	P1IN	EPO
ACT	9/20/1968	Female	P1FA	EPO
ACT	8/16/1985	Female	P1IN	EPO
ACT	7/2/1983	Female	P1IN	EPO
ACT	6/21/1987	Female	P1IN	EPO
ACT	4/13/1981	Female	P1IN	EPO
ACT	5/2/1984	Male	P1FA	EPO
ACT	2/6/1988	Male	P1IN	EPO
ACT	7/13/1986	Female	P1IN	EPO
ACT	7/4/1978	Female	P1FA	EPO
ACT	12/4/1968	Female	P1IN	EPO
ACT	4/24/1988	Male	P1IN	EPO
ACT	9/8/1961	Female	P1FA	EPO
ACT	7/9/1984	Female	P1FA	EPO
ACT	8/29/1954	Female	P1FA	EPO
ACT	4/26/1979	Male	P1FA	EPO
ACT	11/7/1954	Female	P1IN	EPO
ACT	11/19/1985	Female	P1IN	EPO
ACT	8/3/1972	Male	P1FA	EPO
ACT	2/13/1987	Female	P1FA	EPO
ACT	2/21/1987	Female	P1IN	EPO
ACT	10/26/1984	Female	P1IN	EPO
ACT	8/17/1985	Female	P1IN	EPO
ACT	9/15/1964	Female	P1FA	EPO
ACT	3/1/1958	Female	P1FA	EPO
ACT	5/5/1967	Female	P1FA	EPO
ACT	2/26/1988	Female	P1IN	EPO
ACT	8/1/1990	Female	P1IN	EPO

ACT	11/12/1966	Female	P1FA	EPO
ACT	10/8/1989	Female	P1FA	EPO
ACT	4/11/1968	Female	P1IN	EPO
ACT	3/3/1989	Female	P1IN	EPO
ACT	10/10/1987	Female	P1FA	EPO
ACT	8/3/1986	Female	P1IN	EPO
ACT	7/9/1962	Female	P1FA	EPO
ACT	8/9/1950	Female	P1IN	EPO
ACT	7/20/1966	Female	P1FA	EPO
ACT	4/18/1986	Male	P1IN	EPO
ACT	9/4/1984	Female	P1FA	EPO
ACT	5/2/1985	Male	P1IN	EPO
ACT	3/9/1960	Female	P1FA	EPO
ACT	1/28/1980	Female	P1FA	EPO
ACT	6/4/1988	Male	P1IN	EPO
ACT	7/5/1985	Female	P1IN	EPO
ACT	6/16/1964	Female	P1IN	EPO
ACT	9/13/1981	Female	P1FA	EPO
ACT	1/17/1982	Female	P1IN	EPO
ACT	12/10/1952	Female	P1FA	EPO
ACT	11/22/1967	Female	P1FA	EPO
ACT	7/8/1979	Female	P1IN	EPO
ACT	4/28/1979	Male	P1IN	EPO
ACT	12/4/1982	Female	P1IN	EPO
ACT	4/25/1972	Female	P1FA	EPO
ACT	5/6/1977	Female	P1IN	EPO
ACT	9/25/1986	Male	P1IN	EPO
ACT	9/21/1987	Male	P1IN	EPO
ACT	12/13/1954	Female	P1FA	EPO
ACT	4/28/1983	Female	P1IN	EPO
ACT	12/18/1987	Female	P1IN	EPO
ACT	2/3/1987	Female	P1IN	EPO
ACT	5/31/1959	Female	P1IN	EPO
RET	7/27/1953	Male	P1FA	EPO
RET	9/23/1952	Female	P1FA	EPO
RET	4/22/1950	Female	P1FA	EPO
RET	11/5/1950	Female	P1IN	EPO
RET	5/5/1954	Female	P1IN	EPO
RET	4/26/1953	Female	P1FA	EPO
RET	11/24/1949	Male	P1IN	EPO
RET	6/9/1955	Female	P1IN	EPO
RET	4/11/1950	Female	P1FA	EPO
RET	6/27/1952	Male	P1IN	EPO
RET	11/8/1953	Male	P1FA	EPO
RET	7/4/1955	Male	P1FA	EPO
RET	2/2/1953	Female	P1FA	EPO
ACT	11/24/1966	Male	P1FA	OSA

RET	7/7/1956	Female	P1FA	PPO
ACT	8/27/1984	Male	P1IN	PPO
ACT	12/28/1959	Male	P1IN	PPO
ACT	2/4/1947	Female	P1FA	PPO
ACT	6/1/1966	Female	P1FA	PPO
ACT	6/20/1965	Female	P1IN	PPO
ACT	3/29/1968	Female	P1FA	PPO
ACT	11/7/1976	Female	P1FA	PPO
ACT	6/12/1979	Female	P1FA	PPO
ACT	11/30/1957	Male	P1FA	PPO
ACT	4/14/1951	Female	P1FA	PPO
ACT	3/25/1960	Female	P1FA	PPO
ACT	4/24/1947	Female	P1FA	PPO
ACT	1/6/1956	Female	P1FA	PPO
ACT	4/18/1967	Female	P1IN	PPO
ACT	7/31/1947	Female	P1IN	PPO
ACT	11/18/1958	Male	P1FA	PPO
ACT	4/28/1947	Female	P1FA	PPO
ACT	6/30/1969	Female	P1FA	PPO
ACT	1/2/1958	Female	P1FA	PPO
ACT	6/27/1970	Female	P1FA	PPO
ACT	9/19/1968	Female	P1FA	PPO
ACT	6/23/1970	Male	P1IN	PPO
ACT	2/7/1950	Male	P1IN	PPO
ACT	12/21/1944	Male	P1FA	PPO
ACT	12/13/1942	Female	P1FA	PPO
ACT	1/30/1957	Female	P1FA	PPO
ACT	12/9/1954	Female	P1FA	PPO
ACT	4/6/1976	Male	P1IN	PPO
ACT	9/17/1965	Female	P1FA	PPO
ACT	4/3/1949	Male	P1IN	PPO
ACT	12/2/1971	Female	P1FA	PPO
ACT	1/11/1951	Female	P1IN	PPO
ACT	11/1/1956	Female	P1FA	PPO
ACT	7/31/1970	Female	P1FA	PPO
ACT	9/16/1938	Female	P1FA	PPO
ACT	6/8/1965	Male	P1FA	PPO
ACT	11/13/1949	Female	P1FA	PPO
ACT	9/29/1955	Female	P1FA	PPO
ACT	12/18/1977	Male	P1IN	PPO
ACT	8/22/1942	Female	P1FA	PPO
ACT	2/28/1956	Female	P1FA	PPO
ACT	7/18/1967	Female	P1FA	PPO
ACT	1/12/1948	Female	P1IN	PPO
ACT	12/5/1955	Male	P1IN	PPO
ACT	9/15/1959	Male	P1FA	PPO
ACT	9/9/1961	Female	P1FA	PPO

ACT	10/27/1944	Male	P1FA	PPO
ACT	2/7/1956	Female	P1FA	PPO
ACT	6/15/1962	Female	P1FA	PPO
ACT	9/3/1969	Female	P1FA	PPO
ACT	8/16/1977	Female	P1FA	PPO
ACT	2/18/1948	Female	P1IN	PPO
ACT	4/1/1957	Female	P1FA	PPO
ACT	4/18/1951	Female	P1FA	PPO
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ACT	1/26/1968	Female	P1FA	PPO
ACT	2/14/1947	Female	P1FA	PPO
ACT	12/18/1949	Male	P1FA	PPO
ACT	9/11/1978	Female	P1FA	PPO
ACT	12/23/1965	Female	P1FA	PPO
ACT	6/9/1957	Female	P1FA	PPO
ACT	7/13/1979	Female	P1FA	PPO
ACT	1/8/1954	Male	P1FA	PPO
ACT	11/12/1958	Female	P1FA	PPO
ACT	4/29/1955	Female	P1FA	PPO
ACT	7/17/1952	Female	P1FA	PPO
ACT	7/22/1961	Female	P1FA	PPO
ACT	4/19/1952	Female	P1FA	PPO
ACT	2/26/1962	Female	P1FA	PPO
ACT	12/15/1951	Female	P1IN	PPO
ACT	4/13/1972	Male	P1FA	PPO
ACT	2/29/1972	Male	P1FA	PPO
ACT	10/16/1968	Male	P1FA	PPO
ACT	6/6/1957	Female	P1FA	PPO
ACT	2/3/1963	Male	P1IN	PPO
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ACT	12/29/1958	Female	P1FA	PPO
ACT	1/4/1970	Male	P1FA	PPO
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ACT	2/4/1976	Female	P1IN	PPO
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ACT	7/25/1963	Female	P1IN	PPO
ACT	10/24/1953	Female	P1FA	PPO
ACT	8/1/1945	Male	P1FA	PPO
ACT	7/11/1948	Male	P1IN	PPO
ACT	6/20/1959	Female	P1FA	PPO
ACT	9/27/1986	Female	P1IN	PPO
ACT	5/10/1950	Female	P1FA	PPO
ACT	2/10/1986	Male	P1IN	PPO
ACT	12/22/1960	Female	P1FA	PPO
ACT	6/30/1968	Female	P1FA	PPO

ACT	4/9/1948	Female	P1IN	PPO
ACT	5/26/1982	Female	P1IN	PPO
ACT	7/28/1984	Female	P1IN	PPO
ACT	10/22/1959	Female	P1IN	PPO
ACT	2/16/1979	Female	P1FA	PPO
ACT	4/13/1959	Female	P1FA	PPO
ACT	2/16/1952	Female	P1FA	PPO
ACT	12/23/1982	Male	P1FA	PPO
ACT	5/23/1956	Female	P1FA	PPO
ACT	3/4/1982	Female	P1IN	PPO
ACT	12/10/1990	Female	P1IN	PPO
ACT	12/21/1954	Female	P1FA	PPO
ACT	2/25/1988	Female	P1IN	PPO
ACT	4/3/1967	Female	P1FA	PPO
ACT	1/30/1971	Male	P1FA	PPO
ACT	11/28/1952	Female	P1FA	PPO
ACT	1/19/1962	Female	P1FA	PPO
ACT	10/18/1963	Male	P1FA	PPO
RET	9/1/1956	Female	P1FA	PPO
RET	2/24/1953	Female	P1IN	PPO
RET	10/12/1951	Male	P1IN	PPO
RET	5/8/1954	F	I	HMO
RET	8/17/1948	F	I	HMO
RET	12/5/1943	F	I	HMO
RET	7/5/1949	M	F	HMO
RET	11/25/1950	M	F	HMO
RET	9/15/1954	M	I	HMO
RET	2/22/1948	M	F	HMO
RET	10/4/1951	M	F	HMO
RET	9/21/1952	M	I	HMO
RET	7/2/1943	M	I	HMO
RET	7/4/1946	M	F	HMO
RET	12/26/1948	M	F	HMO
RET	7/18/1954	M	F	HMO
RET	11/13/1963	M	I	HMO
RET	6/25/1956	M	I	HMO
RET	7/29/1955	M	F	HMO
RET	11/10/1952	M	F	HMO
RET	6/7/1952	F	I	HMO
RET	4/18/1956	M	F	HMO
RET	8/22/1961	F	F	HMO
RET	4/18/1950	F	I	HMO
RET	3/26/1950	M	I	HMO
RET	7/9/1950	M	I	HMO
RET	3/16/1957	F	I	HMO
RET	9/18/1946	M	F	HMO
RET	3/29/1954	M	F	HMO



RET	6/24/1951	F	I	HMO
RET	3/25/1952	F	I	HMO
RET	2/1/1957	F	F	HMO
RET	10/13/1975	M	F	HMO
RET	1/28/1965	M	F	HMO
RET	1/26/1956	F	F	HMO
RET	7/24/1949	F	I	HMO
RET	4/13/1951	M	I	HMO
RET	12/13/1950	M	I	HMO
RET	2/16/1950	M	F	HMO
RET	8/13/1950	M	F	HMO
RET	4/19/1950	F	F	HMO
RET	11/19/1950	M	I	HMO
RET	6/17/1946	F	F	HMO
RET	9/1/1973	F	F	HMO
RET	5/14/1953	F	F	HMO
RET	1/20/1952	M	I	HMO
RET	12/8/1955	M	F	HMO
RET	8/4/1949	M	I	HMO
RET	1/19/1951	F	I	HMO
RET	9/30/1958	M	I	HMO
RET	10/2/1949	F	I	HMO
RET	9/20/1951	F	I	HMO
RET	4/15/1954	F	I	HMO
RET	8/26/1949	F	I	HMO
RET	3/25/1953	M	I	HMO
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ACT	1/18/1979	M	F	HMO
ACT	11/13/1965	M	F	HMO
ACT	2/22/1963	F	F	HMO
ACT	2/26/1952	F	F	HMO
ACT	2/5/1965	F	F	HMO
ACT	8/25/1959	F	F	HMO
ACT	11/21/1957	F	I	HMO
ACT	2/26/1961	F	I	HMO
ACT	5/13/1972	F	I	HMO
ACT	5/12/1953	M	I	HMO
ACT	12/11/1970	F	F	HMO
ACT	2/3/1954	M	I	HMO
ACT	8/24/1962	M	I	HMO
ACT	12/11/1964	M	F	HMO
ACT	2/10/1962	F	I	HMO
ACT	3/19/1972	F	I	HMO
ACT	7/22/1964	M	F	HMO

ACT	6/19/1948	F	F	HMO
ACT	12/2/1971	F	I	HMO
ACT	5/7/1949	M	F	HMO
ACT	5/15/1965	F	F	HMO
ACT	4/30/1957	F	F	HMO
ACT	7/3/1972	F	F	HMO
ACT	4/28/1968	F	F	HMO
ACT	7/11/1957	M	I	HMO
ACT	2/2/1973	M	F	HMO
ACT	5/20/1972	F	F	HMO
ACT	7/1/1953	M	F	HMO
ACT	3/3/1963	M	F	HMO
ACT	10/23/1951	F	I	HMO
ACT	2/16/1958	F	I	HMO
ACT	12/10/1954	M	F	HMO
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ACT	10/17/1965	F	F	HMO
ACT	2/9/1967	M	I	HMO
ACT	2/14/1947	F	I	HMO
ACT	8/16/1955	M	F	HMO
ACT	3/25/1953	M	I	HMO
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ACT	8/27/1971	F	I	HMO
ACT	6/13/1963	F	I	HMO
ACT	8/1/1963	M	F	HMO
ACT	9/30/1955	M	F	HMO
ACT	8/31/1971	M	F	HMO
ACT	9/22/1968	F	F	HMO
ACT	6/30/1958	F	F	HMO
ACT	3/19/1948	F	I	HMO
ACT	1/26/1951	F	F	HMO

ACT	1/6/1971	F	F	HMO
ACT	1/27/1961	M	F	HMO
ACT	10/20/1957	F	F	HMO
ACT	11/7/1952	F	F	HMO
ACT	6/29/1954	F	F	HMO
ACT	11/29/1963	M	F	HMO
ACT	11/4/1961	F	F	HMO
ACT	12/19/1958	F	I	HMO
ACT	12/16/1955	F	F	HMO
ACT	12/10/1967	F	F	HMO
ACT	3/17/1958	M	F	HMO
ACT	11/3/1954	M	F	HMO
ACT	3/22/1957	M	F	HMO
ACT	1/26/1958	M	F	HMO
ACT	2/1/1961	F	F	HMO
ACT	3/21/1953	F	F	HMO
ACT	9/14/1956	F	F	HMO
ACT	7/3/1952	F	F	HMO
ACT	9/20/1949	F	F	HMO
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ACT	12/23/1956	F	F	HMO
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ACT	5/4/1954	F	F	HMO
ACT	10/2/1948	F	F	HMO
ACT	10/24/1947	M	F	HMO
ACT	2/12/1970	F	I	HMO
ACT	1/11/1949	M	F	HMO
ACT	9/21/1957	M	F	HMO
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ACT	11/16/1961	F	F	HMO
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ACT	9/4/1950	F	F	HMO
ACT	8/16/1956	F	I	HMO
ACT	3/12/1950	F	F	HMO
ACT	5/25/1961	F	I	HMO
ACT	3/1/1963	M	I	HMO
ACT	12/19/1951	F	F	HMO
ACT	8/13/1968	F	I	HMO
ACT	3/19/1974	M	F	HMO
ACT	9/12/1957	F	I	HMO

ACT	6/23/1952	F	F	HMO
ACT	6/23/1950	F	F	HMO
ACT	6/3/1951	F	I	HMO
ACT	1/10/1960	M	F	HMO
ACT	6/10/1971	F	F	HMO
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ACT	1/3/1970	F	I	HMO
ACT	12/18/1963	M	I	HMO
ACT	3/14/1967	M	F	HMO
ACT	5/13/1973	M	F	HMO
ACT	8/20/1965	F	F	HMO
ACT	3/30/1966	F	F	HMO
ACT	1/8/1976	M	F	HMO
ACT	3/29/1972	F	F	HMO
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ACT	9/2/1978	F	F	HMO
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ACT	5/1/1967	M	F	HMO
ACT	5/2/1976	F	F	HMO
ACT	10/18/1977	F	F	HMO
ACT	7/15/1977	F	F	HMO
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ACT	7/29/1977	M	I	HMO
ACT	8/2/1977	M	F	HMO
ACT	1/8/1974	F	I	HMO
ACT	8/2/1964	F	F	HMO
ACT	7/9/1978	M	F	HMO
ACT	9/11/1970	M	F	HMO
ACT	10/11/1976	F	I	HMO
ACT	7/20/1951	F	F	HMO
ACT	10/6/1982	M	F	HMO
ACT	1/24/1971	F	F	HMO
ACT	1/14/1965	M	I	HMO
ACT	7/26/1980	F	I	HMO
ACT	4/16/1966	M	F	HMO
ACT	12/1/1976	F	F	HMO
ACT	7/27/1972	M	F	HMO
ACT	11/23/1976	F	F	HMO
ACT	5/15/1972	F	I	HMO
ACT	4/16/1978	F	I	HMO
ACT	9/12/1974	M	F	HMO
ACT	7/31/1978	F	I	HMO
ACT	4/23/1972	F	F	HMO
ACT	9/19/1978	F	F	HMO
ACT	7/13/1976	F	F	HMO
ACT	12/14/1978	F	F	HMO
ACT	8/11/1951	M	F	HMO

ACT	9/27/1967	F	F	HMO
ACT	6/22/1974	F	F	HMO
ACT	6/3/1965	F	I	HMO
ACT	12/21/1950	M	I	HMO
ACT	6/27/1969	M	F	HMO
ACT	10/7/1964	M	F	HMO
ACT	6/26/1973	M	F	HMO
ACT	1/30/1959	M	I	HMO
ACT	10/13/1979	F	F	HMO
ACT	9/24/1980	M	I	HMO
ACT	11/10/1956	F	F	HMO
ACT	2/18/1981	M	I	HMO
ACT	8/2/1973	F	I	HMO
ACT	3/18/1976	F	I	HMO
ACT	9/4/1977	M	I	HMO
ACT	4/19/1972	F	F	HMO
ACT	3/19/1980	F	F	HMO
ACT	2/9/1960	M	F	HMO
ACT	6/16/1980	F	F	HMO
ACT	12/5/1961	F	F	HMO
ACT	7/18/1973	F	F	HMO
ACT	12/9/1979	F	I	HMO
ACT	8/1/1980	M	F	HMO
ACT	10/10/1955	F	I	HMO
ACT	1/24/1952	M	F	HMO
ACT	3/22/1958	F	F	HMO
ACT	4/8/1968	M	F	HMO
ACT	7/27/1964	F	F	HMO
ACT	8/2/1950	F	F	HMO
ACT	1/18/1962	F	I	HMO
ACT	12/8/1969	F	F	HMO
ACT	12/18/1951	F	F	HMO
ACT	10/14/1950	F	F	HMO
ACT	5/27/1955	M	F	HMO
ACT	9/24/1970	F	F	HMO
ACT	5/24/1976	F	F	HMO
ACT	11/11/1974	F	F	HMO
ACT	9/12/1972	F	I	HMO
ACT	9/14/1954	M	I	HMO
ACT	6/5/1974	M	F	HMO
ACT	3/16/1951	F	F	HMO
ACT	1/24/1969	F	F	HMO
ACT	12/29/1974	F	F	HMO
ACT	2/2/1964	M	F	HMO
ACT	6/6/1951	F	F	HMO
ACT	5/22/1974	F	F	HMO
ACT	11/25/1966	F	F	HMO

ACT	8/20/1976	F	F	HMO
ACT	12/17/1974	M	F	HMO
ACT	6/11/1976	F	I	HMO
ACT	11/4/1974	F	I	HMO
ACT	12/21/1975	M	F	HMO
ACT	10/6/1955	F	I	HMO
ACT	11/6/1953	F	I	HMO
ACT	9/15/1951	M	I	HMO
ACT	5/30/1974	F	F	HMO
ACT	7/20/1976	F	F	HMO
ACT	10/11/1968	F	F	HMO
ACT	3/13/1962	F	I	HMO
ACT	11/25/1969	F	F	HMO
ACT	4/19/1971	M	F	HMO
ACT	1/20/1974	F	F	HMO
ACT	3/19/1972	F	F	HMO
ACT	9/2/1960	F	F	HMO
ACT	7/8/1954	F	F	HMO
ACT	9/1/1968	M	F	HMO
ACT	9/25/1973	F	I	HMO
ACT	4/8/1954	F	F	HMO
ACT	11/7/1974	F	F	HMO
ACT	11/3/1957	M	I	HMO
ACT	6/20/1978	F	I	HMO
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ACT	7/7/1973	M	I	HMO
ACT	5/1/1973	M	F	HMO
ACT	9/11/1944	F	F	HMO
ACT	7/29/1970	F	F	HMO
ACT	4/27/1952	F	F	HMO
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ACT	9/2/1963	M	F	HMO
ACT	4/5/1965	M	F	HMO
ACT	7/18/1971	F	F	HMO
ACT	1/25/1975	M	F	HMO
ACT	12/1/1973	F	F	HMO
ACT	10/14/1961	F	I	HMO
ACT	2/9/1978	F	F	HMO
ACT	10/5/1960	F	F	HMO
ACT	10/2/1961	M	F	HMO
ACT	10/15/1953	M	I	HMO
ACT	3/8/1978	M	F	HMO
ACT	6/9/1950	F	F	HMO
ACT	7/16/1967	M	F	HMO
ACT	7/14/1975	M	F	HMO
ACT	3/16/1973	M	F	HMO

ACT	11/6/1964	F	F	HMO
ACT	6/14/1979	F	F	HMO
ACT	1/29/1979	M	I	HMO
ACT	1/29/1966	F	F	HMO
ACT	7/21/1961	M	F	HMO
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ACT	7/13/1980	M	I	HMO
ACT	6/18/1981	F	I	HMO
ACT	7/28/1976	M	F	HMO
ACT	1/11/1980	M	F	HMO
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ACT	4/22/1982	F	I	HMO
ACT	10/10/1951	F	F	HMO
ACT	12/8/1975	F	I	HMO
ACT	1/18/1986	F	I	HMO
ACT	11/28/1980	F	I	HMO
ACT	4/1/1950	F	F	HMO
ACT	11/12/1973	M	F	HMO
ACT	12/15/1979	M	F	HMO
ACT	5/29/1975	F	F	HMO
ACT	5/7/1971	F	F	HMO
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ACT	6/8/1962	F	F	HMO
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ACT	6/19/1980	M	I	HMO
ACT	5/13/1947	F	I	HMO
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ACT	11/3/1961	M	F	HMO
ACT	1/21/1964	F	I	HMO
ACT	9/21/1981	F	I	HMO
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ACT	5/24/1982	F	I	HMO
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ACT	3/24/1981	F	F	HMO
ACT	2/4/1970	M	F	HMO
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ACT	7/17/1961	F	F	HMO
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ACT	10/12/1979	F	F	HMO
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ACT	5/7/1981	F	F	HMO
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ACT	8/29/1981	F	I	HMO
ACT	7/11/1952	F	F	HMO
ACT	10/24/1971	F	F	HMO
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ACT	12/19/1982	F	I	HMO
ACT	11/22/1972	M	I	HMO
ACT	8/6/1977	F	F	HMO
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ACT	1/8/1975	F	F	HMO
ACT	9/17/1979	F	I	HMO
ACT	9/14/1979	M	I	HMO
ACT	11/21/1974	F	F	HMO
ACT	4/3/1983	F	I	HMO
ACT	5/31/1983	M	F	HMO
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ACT	2/25/1981	M	F	HMO
ACT	7/11/1958	F	F	HMO
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ACT	4/11/1953	M	F	HMO
ACT	12/16/1981	F	I	HMO
ACT	10/1/1983	F	F	HMO
ACT	10/5/1976	F	F	HMO
ACT	8/28/1980	M	F	HMO



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ACT	10/3/1982	M	F	HMO
ACT	5/27/1982	F	I	HMO
ACT	4/11/1953	M	F	HMO
ACT	6/29/1980	F	I	HMO
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ACT	3/29/1981	F	I	HMO
ACT	10/2/1969	M	F	HMO
ACT	5/11/1981	F	I	HMO
ACT	11/2/1981	F	I	HMO
ACT	2/28/1980	F	I	HMO
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ACT	6/8/1984	F	I	HMO
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ACT	11/30/1983	F	I	HMO
ACT	11/4/1972	F	I	HMO
ACT	9/15/1980	F	I	HMO
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ACT	9/22/1961	F	F	HMO
ACT	12/6/1979	F	F	HMO
ACT	5/16/1983	F	I	HMO
ACT	4/25/1980	F	I	HMO
ACT	10/13/1983	F	I	HMO
ACT	2/23/1980	M	I	HMO
ACT	6/24/1949	F	I	HMO
ACT	11/16/1983	F	I	HMO
ACT	4/9/1984	F	F	HMO
ACT	11/17/1978	F	F	HMO
ACT	1/25/1957	M	F	HMO
ACT	9/6/1970	F	F	HMO
ACT	4/19/1983	F	I	HMO
ACT	7/14/1978	F	I	HMO
ACT	10/23/1959	F	I	HMO
ACT	11/29/1963	F	F	HMO
ACT	9/4/1979	F	F	HMO
ACT	8/24/1977	F	I	HMO
ACT	4/17/1957	M	I	HMO
ACT	4/6/1965	M	F	HMO
ACT	9/13/1961	F	F	HMO

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ACT	2/11/1980	F	I	HMO
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ACT	2/13/1969	F	F	HMO
ACT	12/23/1961	M	F	HMO
ACT	6/17/1984	M	I	HMO
ACT	7/12/1985	F	I	HMO
ACT	6/13/1984	F	I	HMO
ACT	8/18/1973	F	F	HMO
ACT	9/6/1986	F	I	HMO
ACT	4/3/1977	F	I	HMO

ACT	9/22/1958	M	F	HMO
ACT	11/22/1947	F	I	HMO
ACT	9/5/1952	F	F	HMO
ACT	5/4/1984	F	I	HMO
ACT	2/26/1984	F	I	HMO
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ACT	1/30/1959	F	F	HMO
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ACT	1/17/1986	F	I	HMO
ACT	9/16/1981	F	F	HMO
ACT	2/12/1982	F	F	HMO
ACT	9/24/1976	F	I	HMO
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ACT	9/30/1959	F	F	HMO
ACT	6/10/1949	F	F	HMO
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ACT	10/13/1951	F	F	HMO
ACT	3/12/1969	M	F	HMO
ACT	3/12/1980	F	F	HMO
ACT	5/11/1966	F	F	HMO
ACT	7/11/1980	F	F	HMO
ACT	8/29/1966	F	F	HMO
ACT	10/8/1948	F	F	HMO
ACT	7/4/1985	M	I	HMO
ACT	1/5/1986	F	I	HMO
ACT	6/27/1973	F	F	HMO
ACT	8/22/1983	M	I	HMO
ACT	7/9/1979	M	I	HMO
ACT	7/17/1978	F	I	HMO

ACT	6/9/1970	F	F	HMO
ACT	6/8/1987	F	I	HMO
ACT	12/19/1968	F	F	HMO
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ACT	2/15/1985	F	F	HMO
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ACT	12/19/1950	M	F	HMO
ACT	1/3/1976	F	F	HMO
ACT	2/7/1980	F	F	HMO
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ACT	7/21/1967	F	F	HMO
ACT	11/18/1967	F	F	HMO
ACT	5/5/1987	F	I	HMO
ACT	4/13/1968	M	I	HMO
ACT	12/3/1961	F	I	HMO
ACT	1/11/1980	F	I	HMO
ACT	11/27/1953	F	F	HMO
ACT	12/3/1957	M	F	HMO
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ACT	5/13/1982	M	I	HMO
ACT	5/9/1986	F	I	HMO
ACT	12/1/1980	F	I	HMO
ACT	9/16/1978	M	F	HMO
ACT	10/31/1972	F	F	HMO
ACT	8/8/1983	F	I	HMO
ACT	11/15/1969	F	F	HMO
ACT	6/29/1987	F	I	HMO
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ACT	12/14/1987	M	I	HMO
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ACT	7/1/1971	M	F	HMO
ACT	12/4/1984	F	I	HMO
ACT	1/2/1983	F	F	HMO
ACT	1/8/1987	F	I	HMO
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ACT	3/29/1952	F	I	HMO
ACT	6/17/1988	M	I	HMO
ACT	6/1/1978	F	F	HMO
ACT	11/19/1987	F	I	HMO
ACT	3/24/1951	F	I	HMO
ACT	7/18/1962	F	F	HMO
ACT	6/15/1949	F	F	HMO
ACT	10/10/1981	M	I	HMO

ACT	8/29/1974	M	F	HMO
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ACT	6/5/1981	M	F	HMO
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ACT	4/24/1979	F	F	HMO
ACT	9/18/1977	M	F	HMO
ACT	3/3/1984	F	I	HMO
ACT	4/14/1984	F	I	HMO
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ACT	6/27/1986	F	I	HMO
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ACT	7/9/1982	F	I	HMO
ACT	11/8/1963	M	F	HMO
ACT	5/21/1981	M	F	HMO
ACT	5/17/1960	F	I	HMO
ACT	8/26/1969	F	F	HMO
ACT	2/25/1986	F	I	HMO
ACT	5/1/1970	F	F	HMO
ACT	7/14/1977	F	F	HMO
ACT	7/1/1986	M	I	HMO
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ACT	1/2/1986	F	F	HMO
ACT	9/11/1986	F	F	HMO
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ACT	5/12/1984	F	I	HMO
ACT	10/19/1981	F	F	HMO
ACT	10/1/1986	F	I	HMO
ACT	4/22/1986	F	I	HMO
ACT	10/28/1978	F	I	HMO
ACT	1/22/1960	M	F	HMO
ACT	2/4/1977	F	F	HMO
ACT	3/17/1985	F	F	HMO
ACT	6/15/1986	F	F	HMO
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ACT	8/27/1966	F	I	HMO
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ACT	1/22/1985	F	I	HMO
ACT	6/30/1986	M	I	HMO
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ACT	12/23/1980	M	I	HMO
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ACT	7/13/1983	F	I	HMO
ACT	4/12/1980	F	F	HMO
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ACT	6/21/1983	F	F	HMO
ACT	6/3/1987	F	I	HMO
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ACT	9/21/1967	M	F	HMO
ACT	10/25/1987	F	I	HMO
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ACT	6/16/1969	F	F	HMO
ACT	1/1/1958	F	F	HMO
ACT	9/20/1989	F	I	HMO
ACT	5/6/1987	F	I	HMO
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ACT	12/28/1974	F	I	HMO
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ACT	8/18/1985	M	I	HMO
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ACT	4/26/1982	F	I	HMO
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ACT	6/25/1965	F	I	HMO
ACT	1/27/1986	F	I	HMO
ACT	7/12/1984	F	I	HMO
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ACT	1/6/1956	F	F	HMO
ACT	11/24/1987	F	I	HMO
ACT	11/8/1985	F	I	HMO
ACT	7/28/1987	F	I	HMO
ACT	4/22/1981	F	I	HMO
ACT	2/26/1987	F	I	HMO
ACT	12/25/1982	F	I	HMO
ACT	7/15/1985	F	I	HMO
ACT	1/31/1968	F	F	HMO
ACT	10/12/1973	F	F	HMO
ACT	4/10/1985	M	I	HMO
ACT	12/9/1984	M	I	HMO
ACT	5/29/1987	M	I	HMO
ACT	8/21/1990	M	I	HMO
ACT	9/17/1987	F	F	HMO
ACT	8/25/1987	F	I	HMO
ACT	7/9/1967	F	F	HMO
ACT	1/31/1970	F	F	HMO
ACT	5/21/1989	M	I	HMO
ACT	3/17/1991	M	I	HMO
ACT	6/8/1987	F	I	HMO
ACT	11/11/1967	M	F	HMO
ACT	12/27/1976	F	F	HMO
ACT	10/19/1982	F	F	HMO
ACT	8/27/1989	M	I	HMO
ACT	7/13/1986	M	I	HMO
ACT	12/30/1985	F	I	HMO
ACT	8/19/1977	F	I	HMO
ACT	3/23/1988	M	I	HMO
ACT	3/17/1988	M	F	HMO
ACT	3/13/1989	F	I	HMO

ACT	10/30/1981	M	I	HMO
ACT	10/22/1985	F	I	HMO
ACT	7/12/1987	F	I	HMO
ACT	11/8/1984	F	F	HMO
ACT	11/9/1986	M	I	HMO
ACT	6/17/1985	F	I	HMO
ACT	4/17/1966	F	I	HMO
ACT	8/29/1990	F	I	HMO
ACT	5/12/1987	M	I	HMO
ACT	10/26/1986	F	I	HMO
ACT	7/6/1985	M	I	HMO
ACT	11/20/1982	F	I	HMO
ACT	10/25/1989	M	I	HMO
ACT	5/29/1985	F	I	HMO
ACT	9/27/1983	F	I	HMO
ACT	9/21/1977	F	I	HMO
ACT	7/15/1985	F	I	HMO
ACT	9/9/1979	M	I	HMO
ACT	5/26/1973	M	F	HMO
ACT	12/5/1990	F	I	HMO
ACT	4/25/1987	M	I	HMO
ACT	12/10/1990	F	I	HMO
ACT	1/1/1961	F	F	HMO
ACT	9/26/1985	F	I	HMO
ACT	11/3/1991	M	I	HMO
ACT	2/2/1978	F	F	HMO
ACT	7/7/1985	M	I	HMO
ACT	8/11/1983	F	I	HMO
ACT	3/16/1985	F	I	HMO
ACT	12/8/1988	F	I	HMO
ACT	8/6/1955	F	I	HMO
ACT	6/12/1985	F	I	HMO
ACT	6/4/1984	F	I	HMO
ACT	4/20/1984	F	I	HMO
ACT	10/17/1986	F	I	HMO
ACT	8/13/1985	F	I	HMO
ACT	11/4/1987	F	I	HMO
ACT	10/9/1986	M	I	HMO
ACT	4/11/1987	F	I	HMO
ACT	6/26/1986	F	I	HMO
ACT	2/25/1985	M	I	HMO
ACT	11/3/1987	F	I	HMO
ACT	4/30/1987	F	I	HMO
ACT	9/20/1986	F	I	HMO
ACT	8/18/1980	F	F	HMO
ACT	3/14/1988	F	I	HMO
ACT	7/21/1962	F	I	HMO



ACT	4/22/1987	F	I	HMO
ACT	6/29/1981	F	F	HMO
ACT	10/12/1970	M	F	HMO
ACT	4/22/1980	M	I	HMO
ACT	2/7/1984	F	I	HMO
ACT	12/29/1986	F	I	HMO
ACT	4/24/1988	F	I	HMO
ACT	11/27/1987	F	I	HMO
ACT	10/24/1978	F	F	HMO
ACT	5/20/1985	F	I	HMO
ACT	2/8/1988	F	I	HMO
ACT	9/6/1978	M	I	HMO
ACT	2/27/1986	F	I	HMO
ACT	5/10/1964	F	F	HMO
ACT	10/20/1961	F	F	HMO
ACT	1/15/1988	M	I	HMO
ACT	9/26/1983	M	I	HMO
ACT	4/26/1983	F	I	HMO
ACT	3/2/1987	F	I	HMO
ACT	1/12/1988	F	I	HMO
ACT	8/20/1986	M	I	HMO
ACT	7/1/1975	F	I	HMO
ACT	6/27/1987	F	I	HMO
ACT	9/18/1981	M	F	HMO
ACT	5/4/1988	F	I	HMO
RET	6/23/1950	M	F	HMO
RET	5/1/1951	M	F	HMO
RET	12/17/1952	M	I	HMO
RET	11/11/1954	M	F	HMO
RET	9/12/1952	M	F	HMO
RET	6/2/1952	M	F	HMO
RET	5/8/1956	F	F	HMO
RET	4/17/1953	F	I	HMO
ACT	10/23/1959	M	F	HMO
ACT	9/12/1967	M	F	HMO
ACT	3/30/1970	M	F	HMO
ACT	6/9/1963	M	F	HMO
ACT	8/13/1968	M	F	HMO
ACT	5/20/1955	M	F	HMO
ACT	1/17/1951	M	F	HMO
ACT	6/10/1963	M	F	HMO
ACT	2/12/1957	M	I	HMO
ACT	3/19/1971	M	F	HMO
ACT	12/11/1974	M	F	HMO
ACT	10/31/1977	M	I	HMO
ACT	10/16/1970	M	I	HMO
ACT	4/4/1973	M	F	HMO

ACT	5/13/1973	F	F	HMO
ACT	8/9/1971	M	I	HMO
ACT	12/7/1955	M	F	HMO
ACT	7/2/1976	M	I	HMO
ACT	7/2/1975	M	F	HMO
ACT	5/12/1977	M	F	HMO
ACT	10/6/1973	M	F	HMO
ACT	11/24/1976	M	F	HMO
ACT	7/7/1981	M	F	HMO
ACT	8/25/1962	M	F	HMO
ACT	6/7/1972	M	F	HMO
ACT	8/26/1974	M	F	HMO
ACT	4/6/1959	M	F	HMO
ACT	7/26/1982	M	I	HMO
ACT	8/9/1976	M	F	HMO
ACT	10/30/1978	M	I	HMO
ACT	7/8/1981	M	F	HMO
ACT	4/23/1982	M	F	HMO
ACT	10/5/1985	M	I	HMO
ACT	10/21/1954	M	F	HMO
ACT	11/30/1977	M	F	HMO
ACT	10/1/1982	M	I	HMO
ACT	9/6/1979	M	F	HMO
ACT	11/1/1984	M	I	HMO
ACT	6/21/1984	M	I	HMO
ACT	8/22/1987	M	I	HMO
RET	2/23/1978	F	F	HMO
ACT	11/17/1952	M	F	HMO
ACT	6/25/1958	M	F	HMO
ACT	6/18/1963	M	F	HMO
ACT	7/19/1956	M	I	HMO
ACT	7/29/1953	M	I	HMO
ACT	6/10/1963	M	F	HMO
ACT	2/9/1945	M	F	HMO
ACT	4/25/1945	M	I	HMO
ACT	10/10/1959	M	F	HMO
ACT	4/29/1953	M	I	HMO
ACT	12/1/1952	M	I	HMO
ACT	11/7/1956	M	F	HMO
ACT	1/14/1946	M	F	HMO
ACT	11/11/1957	M	I	HMO
ACT	6/12/1961	M	F	HMO
ACT	6/1/1953	M	F	HMO
ACT	8/27/1951	M	F	HMO
ACT	12/21/1958	M	F	HMO
ACT	4/3/1953	M	F	HMO
ACT	8/24/1979	M	I	HMO

ACT	6/10/1956	M	F	HMO
ACT	1/19/1953	M	I	HMO
ACT	7/31/1967	M	F	HMO
ACT	4/22/1965	M	F	HMO
ACT	5/17/1954	M	F	HMO
ACT	7/31/1958	M	F	HMO
ACT	6/10/1967	M	F	HMO
ACT	7/20/1980	M	F	HMO
ACT	1/21/1979	M	I	HMO
ACT	4/12/1968	M	F	HMO
ACT	12/20/1973	M	F	HMO
ACT	11/25/1972	M	F	HMO
ACT	7/15/1951	M	F	HMO
ACT	2/17/1983	M	I	HMO
ACT	4/14/1977	M	F	HMO
ACT	12/20/1960	M	I	HMO
ACT	9/8/1969	M	F	HMO
ACT	5/22/1982	M	I	HMO
ACT	9/4/1956	M	I	HMO
ACT	1/11/1967	M	F	HMO
ACT	3/30/1979	M	F	HMO
ACT	9/26/1977	M	I	HMO
ACT	6/7/1968	M	F	HMO
ACT	2/29/1984	M	I	HMO
ACT	12/9/1971	M	I	HMO
ACT	4/18/1979	M	F	HMO
ACT	8/1/1978	M	F	HMO
ACT	11/27/1989	M	I	HMO
ACT	12/9/1964	M	F	HMO
ACT	5/4/1967	F	F	HMO
ACT	10/6/1960	M	F	HMO
ACT	12/15/1970	M	F	HMO
ACT	7/29/1950	M	F	HMO
ACT	3/28/1976	M	F	HMO
ACT	9/7/1973	M	F	HMO
ACT	4/14/1957	M	F	HMO
ACT	1/2/1977	M	F	HMO
ACT	8/17/1977	F	I	HMO
ACT	3/16/1980	M	F	HMO
ACT	1/29/1972	M	F	HMO
ACT	8/26/1983	M	F	HMO
ACT	3/29/1969	M	F	HMO
ACT	5/21/1982	M	I	HMO
ACT	11/5/1986	M	I	HMO
ACT	9/2/1981	F	F	HMO
ACT	5/31/1975	M	F	HMO
ACT	4/29/1978	M	F	HMO

ACT	3/4/1985	M	I	HMO
ACT	12/8/1985	M	I	HMO
ACT	2/4/1988	M	I	HMO
ACT	4/15/1982	M	I	HMO
ACT	3/9/1980	M	I	HMO
ACT	3/23/1988	M	I	HMO
ACT	7/1/1946	F	F	HMO
ACT	12/8/1956	M	F	HMO
ACT	8/15/1960	F	F	HMO
ACT	4/24/1953	F	I	HMO
RET	7/22/1955	F	I	HMO
RET	10/16/1951	F	I	HMO
RET	9/26/1952	M	I	HMO
RET	10/25/1952	F	I	HMO
RET	6/18/1950	F	I	HMO
RET	5/13/1950	F	I	HMO
RET	7/17/1947	M	I	HMO
RET	4/8/1945	F	F	HMO
RET	3/13/1957	M	I	HMO
RET	12/14/1948	F	I	HMO
RET	12/27/1953	M	F	HMO
RET	7/1/1949	F	I	HMO
RET	4/15/1990	F	I	HMO
RET	9/26/1989	M	I	HMO
RET	9/17/1951	F	I	HMO
ACT	8/16/1954	M	F	HMO
ACT	5/27/1964	M	F	HMO
ACT	1/2/1961	M	F	HMO
ACT	4/19/1974	M	F	HMO
ACT	8/11/1956	M	F	HMO
ACT	5/15/1942	M	F	HMO
ACT	8/23/1946	F	I	HMO
ACT	8/28/1954	F	F	HMO
ACT	10/4/1938	F	I	HMO
ACT	9/5/1951	F	I	HMO
ACT	6/7/1953	M	I	HMO
ACT	11/8/1948	F	F	HMO
ACT	6/28/1970	F	F	HMO
ACT	4/6/1957	F	I	HMO
ACT	9/14/1950	F	F	HMO
ACT	1/25/1965	M	F	HMO
ACT	8/7/1953	M	F	HMO
ACT	4/9/1965	F	I	HMO
ACT	9/25/1956	F	F	HMO
ACT	7/8/1947	F	F	HMO
ACT	6/17/1950	F	F	HMO
ACT	12/29/1975	F	F	HMO

ACT	10/25/1956	F	F	HMO
ACT	8/28/1965	M	I	HMO
ACT	4/4/1961	F	I	HMO
ACT	5/31/1973	M	F	HMO
ACT	5/26/1951	F	F	HMO
ACT	12/14/1974	F	F	HMO
ACT	2/6/1966	M	F	HMO
ACT	11/22/1970	M	F	HMO
ACT	6/7/1983	F	F	HMO
ACT	7/14/1977	M	F	HMO
ACT	8/25/1969	M	F	HMO
ACT	5/4/1984	F	I	HMO
ACT	11/11/1954	M	I	HMO
ACT	8/16/1950	F	I	HMO
ACT	5/24/1956	F	F	HMO
ACT	7/27/1960	F	F	HMO
ACT	12/27/1984	M	I	HMO
ACT	8/10/1973	M	F	HMO
ACT	6/23/1980	F	F	HMO
ACT	7/1/1948	F	F	HMO
ACT	4/4/1979	M	F	HMO
ACT	2/6/1964	F	F	HMO
ACT	12/26/1986	M	I	HMO
ACT	1/12/1983	F	I	HMO
ACT	8/26/1986	F	I	HMO
ACT	11/3/1989	M	I	HMO
ACT	9/9/1960	M	F	HMO
ACT	3/7/1986	F	I	HMO
ACT	1/8/1984	M	I	HMO
ACT	8/2/1982	M	F	HMO
ACT	5/27/1986	F	I	HMO
ACT	7/23/1985	F	I	HMO
ACT	10/18/1950	F	I	HMO
ACT	11/18/1949	F	F	HMO
ACT	1/6/1964	F	I	HMO
ACT	7/9/1952	F	I	HMO
ACT	6/15/1954	F	F	HMO
ACT	1/23/1947	F	I	HMO
ACT	6/19/1952	F	F	HMO
ACT	5/22/1950	F	I	HMO
ACT	4/6/1954	M	F	HMO
ACT	5/31/1953	M	F	HMO
ACT	5/14/1956	M	F	HMO
ACT	6/2/1958	M	F	HMO
ACT	12/21/1954	M	I	HMO
ACT	11/28/1977	F	I	HMO
ACT	2/20/1949	M	F	HMO

ACT	6/20/1955	M	F	HMO
ACT	9/13/1952	F	F	HMO
ACT	5/27/1964	M	F	HMO
ACT	8/26/1957	F	F	HMO
ACT	3/22/1971	F	I	HMO
ACT	10/8/1948	M	F	HMO
ACT	7/20/1971	F	F	HMO
ACT	5/13/1954	M	F	HMO
ACT	8/10/1983	F	I	HMO
ACT	2/18/1980	M	I	HMO
ACT	8/1/1989	M	I	HMO
ACT	6/19/1956	M	F	HMO
ACT	10/29/1958	F	F	HMO
ACT	8/3/1990	F	I	HMO
ACT	10/12/1980	F	F	HMO
RET	11/28/1949	M	F	HMO
RET	11/25/1945	M	I	HMO
RET	12/16/1947	M	I	HMO
RET	1/23/1953	M	F	HMO
RET	1/17/1951	M	F	HMO
RET	7/18/1951	M	I	HMO
RET	10/6/1946	M	F	HMO
RET	9/22/1940	M	I	HMO
RET	3/14/1951	F	I	HMO
RET	5/2/1952	F	I	HMO
RET	7/13/1949	M	I	HMO
RET	6/28/1934	F	I	HMO
RET	3/7/1943	F	I	HMO
RET	10/12/1949	F	I	HMO
RET	12/11/1950	F	I	HMO
RET	3/11/1932	F	I	HMO
RET	7/20/1930	F	I	HMO
RET	9/4/1941	F	I	HMO
RET	4/9/1947	M	I	HMO
RET	6/19/1953	M	F	HMO
RET	8/21/1938	F	I	HMO
RET	6/16/1943	M	I	HMO
RET	1/27/1945	F	I	HMO
RET	9/25/1945	F	I	HMO
RET	1/28/1951	F	I	HMO
RET	10/20/1948	F	I	HMO
RET	10/3/1942	F	I	HMO
RET	10/27/1945	F	I	HMO
RET	3/19/1951	F	I	HMO
RET	11/15/1940	M	F	HMO
RET	12/8/1949	M	F	HMO
RET	5/23/1950	F	F	HMO

RET	7/6/1949	F	F	HMO
RET	4/1/1947	M	F	HMO
RET	7/7/1949	F	I	HMO
RET	12/14/1949	F	I	HMO
RET	9/6/1946	F	F	HMO
RET	8/7/1954	F	F	HMO
RET	1/30/1952	M	I	HMO
RET	11/4/1952	F	F	HMO
RET	12/7/1991	M	I	HMO
RET	3/8/1951	M	I	HMO
RET	7/30/1949	F	F	HMO
RET	2/11/1994	F	I	HMO
RET	11/20/1952	F	F	HMO
RET	8/21/1958	F	I	HMO
RET	3/8/1951	F	I	HMO
RET	11/18/1989	M	I	HMO
RET	7/12/1958	F	I	HMO
ACT	3/8/1960	F	F	HMO
ACT	3/4/1951	M	F	HMO